

THE CONTEXT, CONTENT, AND CONSEQUENCES OF DISRUPTIVE BEHAVIOR AMONG NURSES THROUGH PARTICIPANT OBSERVATION AND INTERVIEWS

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ABSTRACT

JACOBA LEIPER: The Context, Content, and Consequences of Disruptive Behavior among Nurses through Participant Observation and Interviews
(Under the direction of Dr. Noreen Esposito)

Disruptive behavior (DB) is a term used in health care to describe a wide variety of unhelpful, hostile, and hurtful behaviors that occur between health care workers. The consequences of disruptive behavior are significant for both nurses and health care organizations. Most studies on DB examine type, frequency, and consequences of disruptive behavior, while few explore how and why it occurs.

While DB occurs among all healthcare workers, this study focused on DB among nurses and aimed to understand how it occurred. The research questions were: a) how do nurses perceive DB in their interactions with other nurses, and b) under what circumstances and in what context does DB among nurses occur. Data collection methods included participant observation, semi-structured interviews, and contextual documents. Data analysis was done using grounded theory techniques and included coding, comparison of data, developing diagrams and matrices, and in-depth exploration of categories.

Findings included that two types of nurses regularly initiated DB on the nursing unit: disruptive nurses (individuals who had a pattern of continual DB) and stress-reactive nurses (individuals who initiated DB only under stressful circumstances). Responses of nurses to DB consisted of a pattern of managing, recovering, and preparing for DB. Solving DB on the unit was difficult for the nurses and unit manager, and in their effort to address DB nurses

reported, confronted, or surrendered to the situation. Each of these strategies had unsatisfactory consequences which lead to the nurses becoming despondent. The result was a seemingly never-ending rise and fall of DB. Lastly, this study identifies that public DB (constant stream of negative comments and complaining to no one in particular) is a form of DB and is very disturbing to nurses.

This study adds to a broader understanding of the occurrence of DB in the nursing workplace and may provide opportunities for the design of preventative interventions at nursing practice and organizational levels for the promotion of a safe and healthy work environment.

DEDICATION

To all nurses.

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CHAPTER 1

A STUDY OF DISRUPTIVE BEHAVIOR AMONG NURSES

This qualitative study explored the phenomenon of disruptive behavior (DB) among nurses in a hospital environment. DB is a term used to describe a wide variety of negative verbal, physical, and work-related behaviors among nurses. The aim of the study was to understand the process of DB among nurses in a healthcare organization by exploring nurses' perspectives of DB, and examining the circumstances and contexts in which DB occurs. I anticipate that the knowledge generated by this study will provide new insights into how and why DB occurs among nurses. Data collection included participant observation, semi-structured interviews, and contextual documents.

This chapter begins with an overview of the background and context of the problem. This is followed by the problem statement and research questions. Also included are discussions of the research approach, rationale and significance, researcher's perspective, and assumptions. The chapter concludes with definitions of key terms.

Background and Context

Disruptive behavior (DB) is a term used in healthcare to describe a wide variety of hostile, hurtful, and intimidating behaviors that occur between workers (Joint Commission, 2008). DB commonly consists of various degrees of verbal, physical, and work-related abuses (Dzurec, Kennison, & Albataineh, 2014; Farrell, 1997, 1999; Farrell, Bobrowski, & Bobrowski, 2006; Joint Commission, 2008, Rowe & Sherlock, 2005). DB among nurses is

also known as horizontal or lateral violence, bullying, incivility, and verbal, physical, or psychological abuse, among many other terms. Behaviors include shouting, criticizing, spreading gossip, isolation, finger pointing, intimidation, unfair work assignment, and many more.

DB has been identified as a problem in healthcare and discussed in nursing literature for more than 30 years. Many articles and studies include references to the societal and historical development of nursing as influences in the development of DB and explain DB using oppression theory (Freire, 1973). Some writers openly argue that DB originated due to the social construction of the female role in society and the historical development of nursing (Alavi & Cattoni, 1995; Dellasega, 2005; Roberts, 2000, 2006). With the constructed role of women as caregivers in western society and nursing's roots in both religious and military models, a foundation of obedience and submission was established. This placed women in an oppressed situation and essentially limited nursing to a specific gender. Nursing education had to uphold society and nursing's standards of creating a "good" or "ideal" nurse (Alavi & Cattoti, 1995; Roberts, 2006). So, harshness of words and treatment, during and shortly after training, ensured the creation of self-sacrificing, loyal, and obedient nurses. The ideal nurse limited her speaking voice, was loyal at all costs, and was strictly obedient to those in power and authority. Thus, DB found early footholds among nurses and continued to thrive.

Alavi and Cattoni (1995) and Farrell (2001) published breakthrough articles which daringly exposed DB and challenged traditional theories. Alavi and Cattoni (1995), in a bold article titled "Good nurse, bad nurse . . .," explicitly described classic recurring examples of DB that started with the development of hospital-based nursing during the 1960s. One

incident involves a new nurse being sent by experienced nurses to obtain vital signs on a deceased patient. The new nurse either became very upset believing he or she found the patient dead or returned with fabricated vital signs, because he or she already experienced negative behavior and degradation from the other nurses when not complying with or failing their requests. This story is told and retold and reenacted by nurses, and consequently DB is perpetuated.

Farrell (2001) wrote an article titled “From Tall Poppies to Squashed Weeds: Why Don’t Nurses Pull Together More?” in response to and to challenge authors who explain DB only in terms of oppression and feminist theories. Farrell stated that DB viewed from these perspectives were limiting and did not include workplace practices (organizational and practice factors) or the nature of interpersonal conflict—factors which are controlled by nurses in most cases. Farrell proposed that the discussion and examination of DB among nurses move beyond “a preoccupation with oppression theory” (p. 33). These authors caused a burst of articles and research on DB.

Currently, the situation regarding DB remains dire. Generally, most articles determine the frequency of behaviors, determine who is most at risk, and examine possible causes and consequences. The prevalence of DB remains high as studies indicate that up to 79% of hospital nurses identify themselves as victims of DB (Chipps, Stelmaschuk, Albert, Bernhard, & Holloman, 2013; Rosenstein & O’Daniel, 2008; Rowe & Sherlock, 2005; Vessey, Demarco, Gaffney, & Budin, 2009). The most frequent source of verbal aggression was nurses, followed by families and physicians.

Studies consistently indicate that victims are usually new younger female nurses, while the perpetrators are the more experienced, senior, or charge nurses (Griffin, 2004;

Roche, Diers, Duffield, & Catling-Paull, 2010; Rowe & Sherlock, 2005; Vassey et al., 2009; Yildirim, 2009). Griffin (2004) found that 96.1% of new graduates ($n = 26$) witnessed disruptive behavior among nurses in their first year, and 46% experienced it. Griffin also noted that 60% of new nurses left their position within the first six months due to some form of negative behavior.

The reasons why DB occurs among nurses is complex. Besides the greater societal and historical influences, organizational factors and specific work practices may play a part. Contextual and circumstantial factors such as organizational tolerance for DB, misuse of authority, lack of autonomy, formal and informal power differences, high workload, time-pressures, problems with the socialization process of new nurses into the profession, lack of effective communication and communication skills, respect, and anger management among many other factors were identified as part of the overall problem of DB (Allan, Cowie, & Smith, 2009; Corney, 2008; Curtis, Bowen, & Reid, 2007; Dzurec et al., 2014; Hutchinson, Jackson, Vickers, & Wilkes, 2006a, 2010; Hutchinson Wilkes, Jackson, & Vickers, 2010; Khalil, 2009; Randle, 2003; Roche et al., 2010). A high rate of nurse turnover and nursing shortage may contribute as well (Griffin, 2004; Lavoie-Tremblay, Wright, Desforges, Galenas, Marchionni, & Drevniok, 2008). Furthermore, organizational structures such as bureaucracy, definitive lines of authority, centralization of decision making, specialization, written policies, and high productivity standards may cause nurses to struggle with their care giving role since there is a conflict between the organizations' need for effectiveness and the nurses' need to provide care (Deetz, 1992; Dellasega, Volpe, Edmonson, & Hopkins, 2014; Duchscher & Cowin, 2006).

The toll of DB can be severe. Victims of DB experience adverse consequences; for example, the nurse may experience emotional effects (anger, fear, frustration); social effects (strained relationships, lowered support); psychological effects (depression, burnout, substance abuse); and physical effects (decreased immune response, cardiac arrhythmias). Rowe and Sherlock (2005) reported ($n = 213$) that reactions included feelings of anger, hurt, frustration, and shock, and long-term effects included lower job satisfaction, negative collegial relationships, lesser sense of well-being, and less trust and support in the workplace.

These consequences in turn affect the organization in terms of decreased patient safety, adverse patient outcomes, decreased quality of care, and a negative work environment, as well as financial effects including reduced productivity, increased staff turnover, increased absenteeism, and increased sick leave (Bartholomew, 2006; Farrell, 1997, 1999; Farrell et al., 2006; Griffin, 2004; Joint Commission, 2008; Rosenstein & O'Daniel, 2008; Rowe & Sherlock, 2005). For example, Rosenstein and O'Daniel (2008) reported ($n = 4,530$) that it provoked stress and frustration, and impaired relationships.

There were also clinical effects of DB: disruptive behavior was related to adverse events, medical errors, and patient mortality (Rosenstein & O'Daniel, 2008). Bartholomew (2006) described an occasion where a nurse was so upset after a disruptive incident that she could not think clearly and overdosed a patient with intravenous morphine. The patient was transferred to the intensive care unit. In the present day complex healthcare arena, we can ill afford these costly consequences.

Problem Statement

The prevalence of DB is high, the reasons why it occurs varied, and the consequences severe for nurses, patients, and healthcare organizations. Most studies focus on the

frequency, type, and consequences of DB and although societal, historical, organizational, demographical, and personal factors have been identified as causes of DB, how and if these factors play a role in creating DB incidents has not been fully explored. Despite the information available, solutions and effective interventions are lacking. The qualitative nature and data collection methods of this study may provide new insight and lead to effective strategies that will lessen the occurrence and impact of DB.

Statement of Purpose and Research Questions

With this study I examined nurses' perspectives, context, circumstances, and overall process of DB in a hospital environment. The aim was to gain a better understanding of the process of DB which may serve as a starting point for potential interventions to prevent DB.

The research questions were:

1. How do nurses perceive disruptive behavior in their interactions with other nurses?
2. How do nurses understand the circumstances and contexts in which disruptive behavior among nurses occur?

Rationale and Significance

Important regulatory institutes, commissions, and organizations acknowledged the problem of DB and its effects in healthcare. The Institute of Medicine (2000) published a report on patient safety—*To Err is Human*—calling for action. The report cites results of many studies regarding communication among healthcare workers, patient care errors, and other safety issues in healthcare. They identify a strong safety culture with elements of clear communication, teamwork, and safe methods to report errors among their priorities. The Joint Commission (2008) considers DB such a widespread problem that it called for the

creation of a Code of Conduct aimed at stopping disruptive and intimidating behaviors among healthcare professionals, effective in 2009. The International Council for Nurses (ICN) also recognized the issue and is hosting its fourth conference on Violence in the Health Sector in October 2014 (ICN, 2014).

The rationale for this study developed from the prevalence of DB among nurses, lack of effective interventions, and my desire to understand and take action to reduce DB among nurses. I believe that as healthcare workers we need to adhere to the ethical principal of “do no harm.” DB causes harm. Increasing our understanding of DB may uncover ways to develop interventions aimed at reducing the behavior. Effective interventions may reduce all the consequences that nurses suffer as result of DB and improve the retention of nurses, especially new-graduate nurses, create a safer work environment for nurses, promote values inherent in nursing (e.g., caring, collaboration, teamwork), promote patient safety, and enhance the general welfare of healthcare organizations.

Research Approach

A qualitative research approach using data collection methods of participant observation, semi-structured interviews, and contextual documents was appropriate for this study. Participant observation refers to a process of learning through exposure to or involvement in the daily lives or routines of the participants in the research setting (Schensul, Schensul, & LeCompte, 1999; Spradley, 1979). This data collection method allowed me to study and experience the workplace context, listen to the nurses, and watch them interact with each other in their natural setting. Semi-structured interviews refer to conversations to “obtain descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena” (Kvale & Brinkmann, 2009, p. 3). Semi-structured interviews

with nurses and other pertinent healthcare workers allowed me to understand DB from the nurses' point of view as they told me about their experiences. Grounded theory is a systematic yet flexible methodology that guides data collection and analysis of the research topic or phenomenon with the purpose of developing a theory (Charmaz, 2006). I did not use grounded theory, but used grounded theory ideas to plan and guide the study and analysis techniques to explore conditions, causes, and consequences of DB.

After approval from my university's Institutional Review Board and the hospital's (study site) Nursing Research Council I started data collection by doing participant observations on one nursing unit for six months. After an initial settling-in period I conducted in-depth semi-structured interviews with 16 nurses from the unit and four other pertinent healthcare workers. In addition, I collected a variety of relevant contextual documents. The information obtained through participant observation and interviews formed the basis for the overall findings, while the texts added context. To my knowledge this was the first and only study to use participant observation as a data collection method on the topic of DB.

Researcher's Perspective

At the time this study was conducted, I was a doctoral student with more than 20 years of hospital nursing experience. I worked as a nurse educator in the academic setting, but had bedside nursing experience in three different countries where I have experienced and witnessed DB many times. I became interested and started exploring the topic while still working at the bedside after hearing about a multitude of DB incidents concerning a particular nurse and wanted to help the nurses who were her victims. A few years later, after entering the academic setting I published an article on the topic (Leiper, 2005). Thus, my

view of DB was influenced by my personal work experience and academic exploration. In 2009 I conducted a pilot study conducting interviews with nurses who experienced DB. The results of that study formed the foundation for this study.

Based on my current beliefs, my understanding of DB is that it is a complex multifaceted problem that is not only influenced by factors such as the historical and societal development of nursing, but also the circumstance and context of the organizational and nursing unit environment. I acknowledge up front that my experiences and prior academic work and research served as initial sensitizing concepts (Charmaz, 2006). To counteract unduly influencing my research, I maintained the grounded theory tradition of diligent and systematic analysis of data and by engaging in reflection. Reflexivity ensured that I critically explored and explained my role as researcher (Dowling, 2006; Wolf, 2007). In this study I had a close relationship with the participants and the work environment, and explicit discussion of all my personal responses adds credibility to the study. Throughout the research process I discussed my findings and interpretations with my participants and dissertation chair.

Assumptions

Based on my experience and background I made the following assumptions. First, that most nurses experience some form of DB from another nurse, but in many cases they do not recognize the behavior as disruptive. My second assumption is related to the first; that nurses view DB among themselves as “normal.” This assumption is based on my personal experience as a student nurse, later as a new nurse in many different hospitals during the development of my career, the long-standing saying of “nurses eat their young,” and the general idea that new nurses have to prove themselves or conform to certain rules of

behavior. Nurses only recognize some common behaviors as disruptive when their awareness of DB is heightened during discussion or education about the topic. Third, that nurses (mostly women) do not effectively deal with DB in the work setting. I base this assumption on my experience, observations, and prior research findings that nurses do not confront each other to resolve an issue, but rather talk to other nurse colleagues about the incident. This allows feelings of anger, frustration, guilt, or grudges that remain unresolved for extended periods of time. Fourth, that the organizational and unit environment influences the amount of DB that occurs among nurses. Again, personal experience and observation during my past 20 years of bedside nursing led me to believe that DB flourishes in some environments where it is allowed (and at times rewarded) by management. An organizational environment where there are time limitations on documentation and performance of tasks, a lack of sufficient staff, an increased workload and pressure on performance, high levels of staff turnover with constant orientation of new nurses, and poor communication among nurses and nurses and management lead to increased tension and stress among all parties that cause DB.

Definitions of Key Concepts

Bullying—Bullying involves repeated forms of negative or hostile behaviors occurring over time which may involve offending, harassing, or negatively affecting the work tasks of the individual targeted (Hutchinson, Wilkes, et al., 2010).

Disruptive Behavior (DB)—Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by healthcare

professionals in positions of power. Such behaviors include reluctance or refusal to answer questions and return phone calls or pages, condescending language or voice intonation, and impatience with questions (Joint Commission, 2008).

Disruptive nurse—A nurse who has a pattern of continual disruptive behavior.

Horizontal Violence—

Horizontal violence most commonly takes the form of psychological harassment, which creates hostility, as opposed to physical aggression. This harassment involves verbal abuse, threats, intimidation, humiliation, excessive criticism, innuendo, and exclusion, denial of access to opportunity, disinterest, discouragement and the withholding of information. (McKenna, Smith, Poole, & Coverdale , 2003, p. 2)

Incivility—“Low intensity, deviant behavior with ambiguous intent to harm the target in violation of workplace norms and mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others” (Hutton, & Gates, 2008, p. 168).

License Practical Nurse (LPN)—A person with one year nursing education at a technical or community college. An LPN works closely with and is supervised by an RN, but has a limited scope of practice.

Nurses—Registered nurses (RN) and Licensed practical nurses (LPN).

Organizational and Unit Environment—Contextual conditions that exist in the healthcare organization or nursing unit (e.g., staffing levels, time constraints, workflow, communication mechanisms, policies and procedures, formal and informal hierarchy, organizational and unit culture, physical outlay).

Registered Nurse (RN)—A person with either a baccalaureate or associate’s degree in nursing.

Stress-reactive nurse—A nurse who initiates disruptive behavior only under stressful conditions (e.g., patient deteriorating rapidly, multiple admissions at the same time).

Chapter Summary

In this chapter, I introduced the study by providing a brief overview of DB. The overview started with the presumed origins of the behavior rooted in societal beliefs regarding the role of women and the historical development of nursing. I discussed current knowledge of the prevalence, causes, and consequences, and present the research questions. The rationale of the study was discussed in terms of the current interest in DB by major regulatory nursing institutes and commissions and the knowledge that lacks. Significance of the study relates to the benefits that can potentially be reaped by having a greater understanding of the problem. I discussed the research approach, my perspective, interest, and bias, and followed this segment with my assumptions about DB. The chapter concluded with key definitions. Overall, the chapter represented a concise rendering of the prelude to and methods of the study.

CHAPTER 2

REVIEW OF THE LITERATURE: AN OVERVIEW

The purpose of this qualitative study is to explore nurses' perspectives of DB and to examine the circumstances and contexts in which DB occurs. The aim is to understand the process of DB among nurses in a healthcare organization. I start this chapter by describing how DB is conceptualized in nursing literature, and follow with a detailed review of quantitative and qualitative studies, addressing specific components of DB. I also briefly discuss theories that explain DB. The material examined contributed directly to my understanding of the problem, in combination with my personal observation and experience, and philosophical perspective led to the development of a research plan that I explain at the conclusion of this chapter.

I now continue with a more concentrated review the literature, focusing on DB among nurses. This concentrated review includes research published since July 2001. Two databases, PubMed and the Cumulative Index to Nursing and Allied Health Literature (CINAHL), were searched. Search terms included "disruptive behavior and nurses and research," "horizontal violence and nurses and research," "lateral violence and nurses and research," "bullying and nurses and research," "incivility and nurses and research," "interpersonal conflict and nurses and research," and "verbal and physical abuse and nurses and research." In addition to electronic databases, reference lists at the end of research articles were examined to locate additional relevant studies. The Internet and Google Scholar

were used to do direct name searches of work by leaders (e.g., Bartholomew, Farrell, Hutchinson, and Griffin) on this topic.

The search was limited to English-language publications of quantitative and qualitative studies that addressed disruptive behavior among nurses or between nurses and healthcare workers. Included studies addressed one or more aspects related to types and frequency of DBs. Exclusion criteria included studies (a) that focused solely on behavior between physicians and nurses, (b) regarding the development or psychometric testing of tools measuring DB, (c) where a type of DB was not the primary focus (e.g., measured related concepts such as burnout or empowerment), and (d) the majority of the sample population were not nurses. A sample of 24 articles was examined for this review.

Since DB is a collective term used to describe a variety of behaviors I will start with how it is conceptualized in the nursing literature.

Conceptualization of Disruptive Behavior in the Literature

Disruptive behavior (DB) is a relatively new term introduced by the Joint Commission to describe a variety of negative behaviors (Joint Commission, 2008). The Joint Commission (2008) defines DB as “overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities” (§2). They note that these behaviors are often manifested by healthcare professionals in positions of power.

Verbal, physical, and other abuses and its effects among healthcare workers have been reported in nursing literature for more than 30 years. Terminology commonly used in the vast majority of studies and journal articles examining this topic includes verbal and physical abuse, bullying, mobbing, lateral or horizontal or interpersonal or workplace

violence, and incivility, among many others. While the definitions, and therefore the meanings, of the terms differ, many researchers and authors use these terms in combination or interchangeably. In addition to the variety of terms, different definitions are used for the same terms. Overall, DB is mostly defined in terms of behaviors. In other words, some authors define terms in an abstract manner, while most list specific behaviors. Appendix A represents a selection of the most commonly used terms and examples of the variety of definitions.

The term “bullying” or “bullying” in combination with another term (e.g., bullying and horizontal violence) is used most in the literature, followed by “verbal abuse” or a combination of “verbal and physical abuse.” Fewer researchers use the other terms (e.g., incivility, disruptive behavior, workplace violence, overt violence, psychological violence, vertical violence, and more). The use of multiple terms and definitions leads to inconsistency and a lack of clarity of the concept which hinders research efforts (Stevenson, Randle, & Grayling, 2006). Adding to the difficulty of conceptualizing DB in nursing is the fact that definitions are seldom clearly operationalized in studies. The term under study is measured by examining behaviors, but there is no clear distinction between the terminology used and the behaviors measured (Leiper, 2010). Studies examining the terms “bullying,” “verbal abuse,” or “incivility” all measure similar behaviors. The wide range of definitions (e.g., repeated behavior or single incident, peer or person in the hierarchy) and selection of behaviors being measured (only verbal or verbal and physical abuse or verbal and sexual) does not present a clear conceptualization of DB. The information of DB in healthcare, among nurses in particular, is bewildering and difficult to synthesize.

To better understand and conceptualize DB, I created a typology of disruptive behaviors (Leiper, 2010; see Appendix B). Three broad categories according to type of abuse became evident: verbal abuse, physical abuse, and work-related abuse. Verbal abuse included three subcategories: overt behaviors (e.g., criticizing, name calling, and blaming); covert behaviors (e.g., sabotage and isolation); and sexual behaviors (e.g., harassment and intimidation). Physical abuse included three subcategories: physical abuse to person (e.g., non-sexual abuse—hitting, slapping); physical abuse to property; and physical abuse—sexual. Work-related abuse included behaviors such as sabotage and use of power. Behaviors in the verbal and physical abuse categories can occur vertically (along a hierarchy) and horizontally (from peer), while those in the work-related category refer mostly to vertical abuse. Using my typology, I found that all studies that I used to create the typology (24 studies over the past 13 years) addressed verbal abuse in some form, three-fourths addressed sexual behaviors, and nearly half addressed physical and work-related abuse (Leiper, 2010).

To add to the complexity of determining what DB consists of, several issues presented with the measurement of DB in quantitative studies (Leiper, 2010). First, most researchers designed their own surveys or modified existing tools. Second, the tools were not used repeatedly and reliability levels were not always reported (Hinchberger, 2009; Longo, 2007; McKenna et al., 2003). Third, different tools were used to measure the same concept. Fourth, behaviors were measured over different lengths of time. Lastly, the answer format of the tools varied greatly. A prime example was studies measuring the most used term, “bullying.” Since 1991, six studies were done measuring bullying among healthcare workers. Three studies used self-designed surveys (Hinchberger, 2009; Quine, 2001; Vessey et al., 2009), two used the Negative Acts Questionnaire (Johnson & Rea, 2009; Simons,

2008), and one used the Workplace Bullying Behavior Scale (Yildirim, 2009). Of these six studies, two measured the behavior over 12 months (Quine, 2001; Yildirim, 2009), two over six months (Johnson & Rea, 2009; Simons, 2008), one during the time that participant was a nursing student (Hinchberger, 2009), and one did not specify a time span (Vessey et al., 2009). The answer format also differed and varied from Likert scales to yes/no to checkbox answers.

In summary, these three factors, (a) the poor conceptualization of DB in terms of definition, (b) poor operationalization, and (c) the limitations in measurement produce fragmented, unclear, and unfocused information preventing the synthesis of data and adding to the complexity of interpretation and determination of the nature of DB in healthcare and among nurses. Clearly further study of the topic is needed. Future studies need to focus on the development of consistent terminology, definition, and instrument use to clarify the concept of DB. Qualitative studies, such as this study and others, will assist in providing foundational concepts to clarify DB, and may provide a better foundation for measurement and exploration of DB in a consistent manner.

The Nurse—And Disruptive Behavior

The literature on DB in healthcare is abundant with studies investigating DB in healthcare (e.g., Dzurec et al., 2014; Farrell et al., 2006; Rosenstein & O'Daniel, 2008; Spence Laschinger, Leiter, Day, & Gilin, 2009). The vast majority study DB in a broad sense, including all healthcare workers in survey questions, while only four studies examined nurse-nurse DB exclusively (Curtis et al., 2007; Dunn, 2003; Longo, 2007; McKenna et al., 2003). In this review I carefully assessed the data in an attempt to isolate DB that occurs

among nurses. Keeping in mind the inclusion and exclusion criteria for this review, the results are particularly troubling.

Prevalence

DB among nurses is a global issue and prevalence is disturbingly high. Several international studies serve as examples: Turkish researchers Celik, Celik, Agirbas, and Ugurluoglo (2007) found that 80.6% of nurses ($n = 622$) reported verbal abuse from another nurse. Spence Laschinger et al. (2009) in a Canadian study reported that 77% of nurses ($n = 612$) reported incivility from a co-worker, while Khalil (2009), a South African researcher, reported a workplace violence prevalence rate of 54% among nurses ($n = 471$). Studies conducted in the U.S. also report notable prevalence. Rowe and Sherlock (2005) found that 75% of nurses ($n = 213$) experience verbal abuse from another nurse, while Rosenstein and O'Daniel (2008) found that 73% of nurses ($n = 2\,846$) witness DB among themselves. Chipps et al. (2013) found 59% of the study participants ($n = 167$) reported witnessing coworker bullying weekly, and 34% reported experiencing at least two bullying acts weekly, and Simons (2008) reported that 31% of nurses ($n = 511$) experience bullying behavior from another nurse at least *daily* or *weekly*. Overall, studies indicate that 17–79% of hospital nurses identify themselves as victims of DB (Vessey et al., 2009). Although epidemiological data of DB are not available, the vast amount of scholarly and anecdotal literature clearly indicates that DB is a significant problem for nurses and healthcare organizations.

Perpetrators

Most studies on the topic of DB include a choice of many perpetrators (e.g., patients, physicians, managers, nurses). Considering the inclusion criteria that the majority of the sample had to be nurses, the data clearly indicate the seriousness of the problem among

nurses. Of the 24 studies reviewed, most indicated the nurse or co-worker as top perpetrator (Budin, Brewer, Chao, & Kovner, 2013, Celik et al., 2007; Khalil, 2009; Lemelin, Bonin, & Duquette, 2009; Rowe & Sherlock, 2005; Spence Laschenger et al., 2009; Vassey et al., 2009) followed by the manager/director/administrator (Johnson & Rea, 2009; Quine, 2001; Yildirim, 2009), and patient/family (Camerino, Estryn-Behar, Conway, van der Heijden, & Hasselhorn, 2008; Farrell et al., 2006; Nachreiner et al., 2007).

Antecedents

The context and circumstances of when DB occurs in the hospital setting is somewhat less explored in the literature. Since context was a crucial part of this study I explored the reported antecedents closely. Quantitative and qualitative studies investigated a variety of causes of DB. Quantitative studies included a variety of variables; to ease the synthesis of this information, I again created a typology where I assessed the type of antecedent addressed by the study. I created four categories: organizational, demographical, personal, and environmental antecedents. Organizational antecedents include skill mix, autonomy, uncertainty of patient treatment, time constraints, work load, and so forth; demographical antecedents include sex, age, education, experience, and so on; personal antecedents include previous history of abuse, work-home relationship, and so forth; and environmental antecedents include gang activity in the area and poor neighborhoods.

Organizational antecedents. Several studies reported similar results. For example, Camerino et al. (2008) in a longitudinal survey study ($n = 34107$) found that work factors such as hours, uncertainty concerning patient's treatment, role conflicts and ambiguity, increased lifting and bending, and time pressures ($\Delta R^2 = 0.09$ ranging from 0.17; $p < .0001$) were significant antecedents. Roche et al. (2010) in a descriptive correlation study ($n =$

3099) found that organizational conditions such as lack of autonomy ($r = -0.26; p < 0.05$), unanticipated changes in patient acuity ($r = 0.07; p < 0.05$), time constraints ($r = -0.02; p < 0.05$), number of nurses ($r = -0.08; p < 0.05$), percentage of patient admissions ($r = 0.07; p < 0.05$) and number of patients awaiting admission ($r = 0.07; p < 0.05$) were all correlated to the amount of workplace violence the nurses experienced. Quine (2001) in a descriptive study ($n = 396$) found that bullying increased when nurses perceived a weak organizational climate of trust. She reported the impact of higher workloads ($M = 3.2, SD = 1.0$ as to $M = 2.8, SD = 0.9, t [1,383] = 4.3, p < 0.001$), greater role ambiguity ($M = 2.5, SD = 1.2$ as to $M = 1.9, SD = 0.9, t [1,387] = 6.4, p < 0.001$), less participation in decision making ($M = 2.9, SD = 1.2$ as to $M = 1.9, SD = 0.9, t [1,389] = 7.8, p < 0.001$), and lower job control ($M = 16.5, SD = 4.3$ as to $M = 19.5, SD = 2.5, t [1,377] = 8.2, p < 0.001$). Budin et al. (2013) in a descriptive study ($n = 1407$) found similar results regarding autonomy, support, and nurse satisfaction. Yildirim (2009) in a descriptive correlation study ($n = 286$) found that bullying positively correlated with increased workload ($p < 0.05$). In Anderson's (2002) descriptive study ($n = 67$) nurses indicated that poor staffing, long hours of work, and not knowing how to deal with workplace abuse were contributing factors.

Demographic antecedents. Vassey et al. (2009) in a survey study ($n = 303$) found that nurses who worked on medical surgical units were bullied most (23%), followed by critical care (18%), and emergency room (12%). Camerino et al. (2008) in a longitudinal survey study ($n = 34107$) found that nurse-nurse violence most often occurs in intensive care units (7.4%), followed by geriatric units (7%), and medical-surgical units (6%).

Vassey et al. (2009) found that nurses who worked five or less years on a unit (58%; $n = 122$) were bullied more than nurses who worked on the unit for a longer period of time.

Yildirim (2009) in a descriptive correlation study ($n = 286$) found that bullying was positively correlated to total years working ($p < 0.05$) and negatively correlated to the nurse's age ($p < 0.01$). Bullying was not associated with nurses' education level. However, Lemelin et al. (2009) in a descriptive correlation study ($n = 181$) found that gender ($r = .17$; $p = 0.05$) and education ($r = .16$; $p = 0.05$) yielded significant correlations. Women were more exposed to psychological abuse than men. More advanced education resulted in less workplace violence and younger nurses were more exposed to physical and sexual abuse than older nurses. Violence from a colleague was also related to years of experience ($r = -.12$; $p = 0.05$). Less experienced nurses experienced more violence from a colleague. Roche et al. (2010) in a descriptive correlation study ($n = 3099$) also found that the higher level of education the nurse has, the less violence she experiences ($r = -.22$; $p = 0.05$). Camerino et al. (2008) yielded similar results in their longitudinal survey study ($n = 34107$). They reported that younger nurses (< 30 years), experienced more violence from colleagues (6.3%) compared to older nurses (> 45 years; 5.2%); nurses with higher education experience less (5.2%) than those with lesser education (6.9%); and that nurses born in another country experience more violence (6.6%) from a colleague than those who were locally born (5.4%). Interestingly, Budin et al. (2013) in their study ($n = 1407$) found that nurses experience more verbal abuse from colleagues who were unmarried.

Personal antecedents. Anderson (2002) in a descriptive study ($n = 67$) attempted to determine if a history of childhood or adult abuse contributed to being a victim of workplace violence, but found this not to be statistically significant. Dion (2006) in a descriptive correlation study ($n = 115$) assessed the impact of work-family conflict (demands of work interfere with home responsibilities) and family-work conflict (demands of family interfere

with work responsibilities) on incivility at the workplace. Neither was found to be statistically significant.

Environmental antecedents. Anderson (2002) in a descriptive study ($N = 67$) found that hospital location and the presence of gang activity in the area were identified as contributing factors.

Consequences

Many studies address the consequences of DB. To present findings in an organized manner I have categorized the consequences according to those associated with the nurse, the organization, and the profession. Since there is so much information, I will illustrate the consequences with a few studies.

The nurse. The psychological, emotional, and physical effects on the nurse are highly evident. Nurses feel that their health is affected; they experience weight loss, headaches, palpitations, and chest pain; they feel unwanted, undervalued, miserable, depressed, frustrated, angered, anxious, stressed, and humiliated; they take time off, do not want to go to work, and have reduced confidence and self-esteem (Camerino et al., 2008; Chipps et al., 2013; Hutchinson et al., 2006a; McKenna et al., 2003; Nachreiner et al., 2007; Quine, 2001; Rosenstein & O'Daniel, 2008; Rowe & Sherlock, 2005; Yildirim, 2009). A few studies serve as examples: Quine (2001) found that 87% of nurses ($n = 396$) who experienced bullying felt miserable and depressed and 82% did not want to go to work. McKenna et al. (2003) found that 58% of nurses ($n = 551$) who experienced horizontal violence felt undervalued and unwanted, and Rosenstein and O'Daniel (2008) found that 94% of health care workers ($n = 4530$) who experience DB stated that it led to stress and frustration.

The organization. The health care organization is negatively impacted by DB in terms of turnover, intent to leave, productivity, patient safety, organizational climate, and commitment (Camerino et al., 2008; Dion, 2006; Hutton & Gates, 2008; Laschinger, Finegan, & Wilk, 2009; Rosenstein & O'Daniel, 2008; Vessey et al., 2009; Yildirim, 2009). Rosenstein and O'Daniel's (2008) study was most influential in the decision of the Joint Commission to mandate a Code of Conduct for hospitals. They found that 71% of health care workers ($n = 4530$) felt that DB led to medication errors, 67% to adverse patient events, and 27% to increased patient mortality. Spence Laschinger (2013) in a descriptive study ($n = 336$) found that bullying from nurses had significant direct and indirect effects on nurse-assessed adverse events ($R^2 = 0.03-0.06$) and perceptions of patient care quality ($R^2 = 0.04-0.07$). Roche et al. (2010) also found that nurses ($n = 3099$) reported that DB was associated with patient falls, medication errors, and late administration of medications. Dion (2006) in a study of nurses ($n = 184$) found a significant relationship between DB and decreased production ($p = 0.001$) as did Yildirim (2009, $n = 286$, $p < .0001$). Spence Laschinger et al. (2009) found that DB was the strongest predictor for job satisfaction among nurses ($N = 1106$, $p < 0.001$). Vessey et al. (2009) found that 49% of nurses ($n = 303$) lost interest in their job and 50% had the desire to resign after experiencing DB. Yildirim (2009) also found a significant relationship between DB and intent to leave ($n = 286$, $p < 0.001$). These findings are consistent with Camerino et al. (2008), who reported that increased DB is related to lower organizational commitment ($n = 34107$, $p < 0.001$).

The profession. With the disturbing consequence of DB being related to intent to leave and lower organizational commitment, recruitment and retention of nurses is essential, especially in view of the projected change in population demographics as a consequence of

baby boomer retirement. A dramatic increase in the aging patient population is expected, and simultaneously, experienced nurses, baby boomers themselves, will also be retiring (Bell, 2013; Fox & Abrahamson, 2009; Sherman, Chiang-Hanisko, & Koszalinski, 2013). The poor retention of new graduate nurses due to DB may play a significant part in a future nursing shortage. The estimated cost of recruiting and orienting a new graduate is about \$44,000 to \$49,000, making DB a financial drawback (Beecroft, Kunzman, & Krozek, 2001; Halfer, 2007). New graduates and student nurses are particularly vulnerable to DB due to their situation of inexperience and dependence (Griffin, 2004; Longo, 2007; Randle, 2003). Beecroft et al. (2001), Winter-Collins and McDaniel (2000), and Griffin (2004) reported that 35%–60% of new graduates leave within their first year due to the workplace environment, DB, increased stress, and pressure.

Reactions

How nurses react after a DB incident is important because it may reflect the value they attach to the behavior, or the value they perceive the organization attaches to the behavior, and their gendered response. Ferns and Chojnacka (2005) reported that nurses have a “culture of non-reporting” (p. 53). Reasons for underreporting DB included that DB is seen as routine, reporting incidences were time consuming, lack of awareness of the reporting system, reporting incidences had not led to change, and the nursing ethic of coping, among others. Farrell (1999) found that nurses ($n = 270$) most often attempt to deal with an incident by talking to colleagues, a friend, a concerned person, a family member, and manager—in that order. Vassey et al. (2009) in a descriptive study ($n = 212$) found similar results with less than 50% of the nurses in acute care settings reporting DB. These findings were consistent with the results of the study that I conducted (Leiper, 2009). Nurses stated

that they coped with DB by talking about it to colleagues, because they felt that management did not take any action and allowed these behaviors to occur without any real consequence to the perpetrator.

Another most disturbing reaction was found by Randle (2001, 2003). Student nurses who were exposed to and experienced DB internalized the behavior and started treating others the same way. Farrell (2001) supports this finding in his discussion of why DB occurs among nurses, stating that “aggression breeds aggression” (p. 30) mainly because it gets results which reinforces the behavior, thus perpetuating it. Since DB is commonplace, nurses see it as part of the job, learn it as they socialize into nursing, maintain it as part of their culture, and use it to their benefit.

Data from Qualitative Studies

While quantitative studies are very helpful in pinpointing specific variables and reflect the underlying nature of nursing in the organization, these factors do not tell the whole story of how DB occurs. Qualitative studies have exposed some of alternate aspects related to DB, but unfortunately with only a few published, the mechanisms at work have not fully been exposed or explored.

Australian researchers Hutchinson, Vickers, Jackson, and Wilkes (Hutchinson et al., 2006a; Hutchinson, Vickers, Jackson, & Wilkes, 2006b, 2006c, 2007, 2008; Hutchinson, Vickers, et al., 2010; Hutchinson, Wilkes, et al., 2010) have done the most qualitative work, and have revealed a wealth of knowledge to help the nursing community understand the intricacies of DB. Their initial studies focused on nurses and student nurses’ stories and experiences. These studies identified concepts such as othering, legitimization of power, formation of alliances, rules of work, and indoctrination, among others. Subsequent studies

moved to an organizational perspective leading to the development of a theory and model (Hutchinson, Vickers, et al., 2010; Hutchinson, Wilkes, et al., 2010; see Appendix C). Their theory and model was based on their prior findings and the existing organizational theories of Clegg (1989) and Salin (2003). Hutchinson, Wilkes, et al. (2010) tested their model and found that three organizational factors contribute to DB among nurses ($n = 370$). The organizational factors are (a) informal organizational alliances (groups of nurses who act together, cliques, old girls' clubs), (b) organizational tolerance or reward of DB, and (c) misuse of legitimate authority, processes, and procedures. Informal organizational alliances are related to organizational tolerance and reward ($r = 0.77, p = 0.05$) and misuse of legitimate authority ($r = 0.74, p = 0.06$). In turn organizational tolerance ($r = 0.66, p = 0.13$) and misuse of authority ($r = 0.23, p = 0.11$) is related to bullying. Alliances that form among nurses who engage in DB developed into cooperative, deliberate, and planned activities of destructive behavior and fostered a tolerance for abusive behavior. These nurses "could do what they like, write their own rules, and work together" (Hutchinson et al., 2006a, p. 229). Within nursing teams where DB is rife, abuse becomes normalized and surveillance and control is exercised through power structures that are easily hidden behind legitimate organizational authority, rules, or procedures. This behavior in combination with organizational tolerance creates power structures that normalize DB as an accepted part of nursing culture. New nurses are particularly vulnerable during socialization into the profession as they often endure an initiation or indoctrination process while learning the "rules" of the job. When an organization is tolerant of this type of behavior it becomes part of the organization and unspoken strategic power relations develop between alliances and members of the upper hierarchy that ensure compliance and obedience through coercion and

abuse. Simultaneously, victims are silenced, or when they complain, are labeled as deserving of ill treatment and eventually minimized, ignored, and denied (Hutchinson et al., 2006a; Hutchinson, Wilkes, et al., 2010).

Randle's (2003) study supports some of the above findings. She conducted a three-year study with nursing students ($n = 43$) and set out to explore how changes in their self-esteem influences patient care. A major finding was that the prevalence of bullying directed toward the student nurses had negative effects on self-esteem. Power relationships were at the forefront during the socialization process of students which included undermining their self-esteem, an initiation process to gain a sense of belonging, and most disturbingly, the adoption of norms and rules of the dominant group. The internalization of abusive behaviors toward other nurses perpetuates the prevalent nursing culture. Allan et al. (2009), using case study methodology ($n = 3$), found that abusive power relationships in combination with poor communication contribute to DB. They found that ineffective communication regarding minor issues escalated to rude and abusive language that quickly led to major consequences. Khalil (2009) in the first stage of her ethno-phenomenological study collected survey information from 471 nurses. She also found that lack of effective communication among nurses, as well as lack of respect and anger management led to DB.

Old and New Theoretical Perspectives

To find reasons for DB among nurses, many nurse scholars turned to theoretical explanations over the years. Many nursing scholars have explained DB among nurses in hospital settings in terms of Freire's (1973) oppression theory, and lately Clegg's (1993) circuits of power theory and Salin's (2003) model of enabling, motivating, and precipitating structures and processes in the work environment that contribute to bullying (Bartholomew,

2006; Matheson & Bobay, 2007; Roberts, 2000, 2006; Hutchinson et al., 2006b; Hutchinson, Vickers, et al., 2010; Hutchinson, Wilkes, et al., 2010). All these theories fit under the umbrella of critical social theory (CST). Freire's (1973) oppression theory is a prime example of CST, while Clegg's circuits of power and Salin's model are variations of CST (Calhoun, 1995; Morrow & Brown, 1994).

Oppression Theory

According to oppression theory (Freire, 1973) as a result of constraints imposed by the dominant culture (e.g., physicians, the medical model, hospital administrators, health insurance companies, etc.) some nurses are not able to express themselves freely. The consequent accumulation of unreleased tension causes nurses to lash out at each other.

Oppression theory is relevant since historically nursing (94.4% women) is viewed as a servile and subordinate job by our society and feminist theorists believe that patriarchal and capitalist structures that cause the oppression of women are reproduced in the hospital workplace (Davies, 1995; Dellasega, 2009). The vast majority of articles and studies on DB mention or apply oppression theory.

Circuits of Power Theory

A second theory that has been used to explain DB among nurses is based on the work of Clegg's (1993) circuits of power theory (Hutchinson et al., 2006b). This theory describes three circuits of power: episodic agency power (micro level/interpersonal), dispositional power (macro level/social integration), and facilitative power (macro level/systems integration). Hutchinson et al. (2006b) explored and applied the dispositional power circuit to nursing. This circuit represents social integration and there is a focus on symbolic power of rules of practice, relationships of meaning, and group membership (us/them). In this

circuit rules are fixed and meaning is created, contested, and stabilized. The dispositional power circuit suggests that power operates in groups, and negative behavior directed toward members who do not conform to group norms helps to maintain order in the group, strengthening the circuit of power. For example, most nurses on a unit follow the same rules and procedures—they assimilate into the circuit of power. When one nurse resists and breaks a rule, the other nurses will see him or her as a failure and target the individual with negative behavior until the resistance is overcome and the smooth flow of the circuit is restored, maintaining order within the unit. Negative behavior is thus seen as “normal” (Hutchinson et al., 2006b).

Salin’s (2003) Model of Enabling, Motivating, and Precipitating Structures and Processes in the Work Environment That Contribute to Bullying

Essentially, the model addresses organizational antecedents of DB. Antecedents fall into three groups of conditions: (a) enabling (necessary conditions), (b) motivating (good conditions), and (c) precipitating (trigger conditions) structures and processes in the work environment. Enabling conditions are the most important and allow DB to occur (or not occur). They serve as a control. The model indicates that an interaction of enabling factors with at least one of the motivating (good conditions) *or* precipitating (trigger conditions) structures and factors is necessary to lead to DB. In other words, enabling conditions need to be present for DB to occur and at least one motivating or precipitating condition has to be present. For example, if a situation exists in an organization where a perpetrator of DB receives awards (motivating factor) and there is a low cost to the perpetrator (enabling factor), DB will occur in the organization. Similarly, if there are frequent changes in the composition of the work group (precipitating factor) and high levels of high levels of dissatisfaction and frustration (enabling factor), DB will occur (see Appendix C).

Hutchinson, Vickers, et al. (2010) and Hutchinson, Wilkes, et al. (2010) integrated components of this theory when they developed their theory (described in earlier section).

Limitations of These Theories

These three theories explain some aspects of DB among nurses, but they are not comprehensive. Oppression theory explains DB from a larger societal context in terms of two groups struggling with power. Circuits of power theory (Clegg, 1989), Salin's (2003) model, and Hutchinson, Wilkes, et al. (2010) have the potential to explain DB from an organizational perspective. They do not address the intricacies of the behavior within one group—the narrower perspective—the nurses actually experiencing it and the meanings they derive from it. This study will present nurses' perspectives, where individual characteristics, interpersonal interactions, individual and/or group behavior, and the work context may be important.

Research Study Plan

To be successful with this study, I developed a research plan to help focus and shape the research process (Bloomberg & Volpe, 2008). My research plan was based on exploring and understanding DB which started with the research questions. The literature and data from my pilot study, where I used the same research questions, provided valuable sensitizing concepts (initial ideas) that I used as starting points (Charmaz, 2006). My plan was flexible, fluid, and essentially a working tool that I continually revised and refined during the course of the study.

To create the first rendering of the research plan I examined each question and developed descriptors and sensitizing concepts for each. The first question, "How do nurses perceive disruptive behavior in their interactions with other nurses?" is complex in nature

and deals with nurses' viewpoints of DB. It reaches out to the collective meaning and experience of DB.

Perception—feelings about DB, feelings, sequence of event, reactions during/after, decisions during/after, influences, and judgments.

Interview questions explored nurses' thoughts, feelings, and reactions of DB. By eliciting information about how DB events happened, how they felt about it, reacted, and what the consequences were, I got a sense of the meaning of DB. Through participant observation I confirmed nurses' perceptions and experiences. As the study progressed I developed categories from the data about DB that occurs in public and problems with reporting DB; since I did not anticipate this I included more questions and exploration about these two categories.

The second question, "How do nurses understand the circumstances and contexts in which DB among nurses occurs?" deals with circumstances and contexts—two concepts that overlap to some extent.

Circumstances (when)—to determine circumstances that lead to DB, I coded specific circumstances or conditions at unit level, for example, report time, sudden or unexpected increase in workload, emergency situations, time constraints, dependence on others, poor communication, among others.

Context (who, when, where, why, how)—to determine the context in which DB occurs I planned to examine broad and narrow contexts. Broad contexts included organizational factors, but after I started the study I found that due to the nature of DB on the unit and the nurses' focus on what was happening in their immediate environment I could not do that. I adjusted and concentrated only on the nursing unit and nurses (e.g., who was involved in DB,

when it happened, chain of command, policies and procedures, physical layout, discourse, body language, dress, demographic information of nurses, etc.).

I used grounded theory techniques for data analysis. I followed the traditional procedures of initial and then focused coding (Charmaz, 2006). I developed categories from the codes which I then explored, further focusing on data that would add new knowledge to the existing literature.

Summary

In summary, while much knowledge of DB exists, the fragmented nature and poor conceptualization of DB hinders progress on understanding the complete picture of all the influences involved in creating the phenomenon. Studies highlight the prevalence of DB among nurses and show that nurses are the leading perpetrators. Specific working conditions such as increased work load, uncertainty regarding patient condition or treatment, staffing levels, time constraints, and autonomy, among a few other related conditions, are clearly identified as potential causes of increased DB among nurses. The type of nursing unit may also be a factor, with units that deliver higher levels and more complex care identified as places where DB occurs most. Interrelationships among the nurses were also identified as important with younger, less experienced nurses being the victims. Personal antecedents were not significant. One small study explored environmental antecedents and these may contribute to DB.

Qualitative studies exposed and identified new dimensions of the problem of DB among nurses. The more intricate processes and interrelationships of group formation, power play, communication, and socialization, and how these are connected and situated within

organizational structures were identified. Hutchinson et al. has done the most qualitative work on the topic of DB and developed a theory based on organizational antecedents.

Theoretical explanations for DB have for the most part been limited to oppression theory which is a broad social theory and limited in its use at the nursing unit level. Present day researchers are exploring other theories such as Clegg's (1993) circuits of power and Salin's (2003) model of enabling, motivating, and precipitating structures and processes in the work environment that contribute to bullying.

I conclude the chapter with a description of a research plan that I developed to focus and shape the study. I included ideas of how I developed the plan and how I adapted and changed data collection as the study progressed.

CHAPTER III

METHODOLOGY

The purpose of this qualitative study was to explore DB among nurses on a unit in a hospital environment. This chapter details my research approach (including data collection methods and analysis approach), the research setting, gaining entrée to the healthcare facility and sampling the nursing unit, and entrée into the nursing unit. Next I set the scene by describing the nursing unit and a nurse's typical day. I then describe exactly how I collected data by conducting participant observations and semi-structured interviews. I report how I managed, analyzed, and synthesized the data. I conclude the chapter discussing issues of trustworthiness.

Research Approach

The research approach for this study was developed from the research questions. Many quantitative studies had been done on the topic of DB, but I believed that they were limited by presenting data from questionnaires administered once with predetermined answer choices. Quantitative studies were done by providing paper or online questionnaires; there is no personal connection to the participant to ensure accurate information or consideration of context or circumstances. Qualitative studies presented data from interviews and mainly focus on the stories about the phenomenon and less on the process, context, and circumstance of how it occurred. With these studies the researcher and a nurse meet, two strangers, to discuss a disruptive event. The researcher has no firsthand knowledge of the nurse or the

context of the work environment. I believed that an in-depth approach of direct observation of DB that included the nurses, context, and circumstances as it happened would fill the gaps in the knowledge base of this problem. Observation, especially over an extended time period, and first-hand knowledge of the nurses, their actions and reactions in the work environment was important to me and would provide data that are more comprehensive. Therefore, I took a qualitative research approach that included participant observation. Qualitative research examines a social situation or interaction by allowing the researcher to enter the participants' world by various data collection methods (Patton, 2002). There is an emphasis on discovery, description, and extracting the meaning of the experience.

In preparation for undertaking this dissertation I conducted a qualitative pilot study at the same hospital where I planned to complete this study. I explored the same research questions of “How do nurses perceive DB in their interactions with other nurses?” and “Under what circumstances and in what context does DB among nurses occur with a small number of nurses?” I interviewed four nurses about their experiences with DB. I learned that interview data alone was limited, and to really understand the phenomenon and understand the processes by which DB takes place I needed to do more than a single interview with a nurse I did not know and add another data collection method. After discussion with my academic advisor I decided to collect data doing semi-structured interviews as before, but to add participant observations as an equally important data collection method. In addition, I collected relevant contextual documents (e.g., Code of Conduct, copies of nurses' letters of complaints).

Participant Observation

Participant observation refers to a process of learning through exposure to or involvement in the daily lives or routines of the participants in the research setting (Schensul et al., 1999; Spradley, 1979). Participant observation is characterized by the researcher entering the social world of the participants and understanding it from their point of view. It is a naturalistic method where the social reality of the group under study is understood through their perceptions, meanings, and understandings (Schensul et al., 1999; Spradley, 1979, 1980). Participant observation included observing details of the setting, routines and sequences of events, relationships, and differences among the people under study. Characteristics (dress, ages, gender, and race); the patterns, frequency, and directions of interaction; language; and behaviors can be observed (Patton, 2002; Schensul et al., 1999; Smith, 2006). Not only can the researcher experience the setting, textures, noise levels, and smells, but they can also participate in activities with the participants. Opportunities for routine conversations and interviews helps the researcher understand, interpret, and capture the meaning of behavior. Placing yourself in context and observing individuals over time is vital to producing very detailed rich data that cannot be obtained through individual interviews alone.

I have no experience with participant observations, but it exposes the way a group is organized, how they relate to each other, and over time patterns of behavior will become clear. I believe that if I have key informants they may expose me to different situations and people: I can discuss events or behaviors with the nurses, I may witness a DB event, and I can notice suppressed and hidden aspects in the group (Patton, 2002; Schensul et al., 1999; Spradley, 1980).

Semi-structured Interviews

The semi-structured interview is a method whereby data are collected through conversation, from the interviewee's point of view—his or her experience. Semi-structured interviews are very flexible and will allow the conversation to flow naturally (Charmaz, 2006; Kvale & Brinkmann, 2009; Richards & Morse, 2007; Schensul et al., 1999; Spradley, 1979). Interviews were face-to-face, sitting down together for a conversation. Eye contact can be made and body language and non-verbal cues can be observed; for example, comfort, discomfort, or nervousness. Good rapport and trust can be developed between the interviewer and interviewee, which may lead to better data (Kvale & Brinkmann, 2009).

In semi-structured interviews the questions are open-ended and the interview usually starts with a broad sweeping question before moving on to more specific questions that follow up on information provided (Kvale & Brinkmann, 2009; Spradley, 1979). Follow-up questions can also be probing, specifying, structuring, interpreting, direct, or indirect, and usually involve who, what, when, where, why, and how questions. Even though the interview follows the nurses' line of thought, it also allows information about specific topics, especially in the latter part of a study when patterns or ideas identified during analysis need further exploration. Similar questions can be asked to nurses that will allow for comparison of data. Semi-structured interviews usually provide rich in-depth data about the topic in question (Charmaz, 2006; Richards & Morse, 2007; Spradley, 1979).

The richness of the data depends on the researchers' interview ability, the questions asked, and the amount of shared trust. In-depth information about a topic can be obtained doing semi-structured interviews (Kvale & Brinkmann, 2009; McCaffery, 2003; Richards & Morse, 2007). Fortunately, by doing a pilot study I had an interview guide and some

experience doing semi-structured interviews on the topic of DB. An added benefit was that I had observed the nurses working in their natural work environment and seen them experience, witness, and react to DB.

Data Analysis Approach

Grounded theory analysis techniques provided the best fit for my research purpose and questions (Charmaz, 2006; Wuest, 2007). The purpose of grounded theory is to demonstrate the causes and conditions under which a situation or phenomenon occurs and to describe the consequences. The outcome of grounded theory is a theoretical framework or model that explains the phenomenon. With this study I did not do a grounded theory, but used appropriate principles and ideas (e.g., staying close to the data, focusing on a phenomenon, sensitizing concepts) and analytical methods (e.g., coding, developing categories, memoing, reflecting) to shape the study and analyze the data. Later in the chapter is a detailed rendering of how data were analyzed.

Research Setting

I conducted the research at a large teaching non-profit hospital system in the southeastern region of the U.S. The hospital system consisted of four joined hospitals (799 beds) and numerous affiliated clinics. It predominantly served the state in which it was located, but accepted patients nationwide and worldwide for specialty care. The hospital employed more than 1,700 nurses, a workforce that includes diversity of race, gender, age, experience, level of education, and work status (personal communication, April 13, 2010). The hospital had 10 types of service areas (e.g., women's, children's, cardiac, oncology, emergency room, medical, psychiatric and rehabilitation, surgical services, and radiology) containing 43 nursing units that varied in patient population and included specialized units.

Gaining Entrée and Sampling of Nursing Unit

Gaining entrée to the hospital. Gaining entrée or “getting in” is the process of making yourself known to the research setting and the start of building relationships with the nurses that I wanted to study (Lofland, Snow, Anderson, & Lofland, 2006; Schenshul et al., 1999). The first step was to obtain formal permission to conduct the study in the healthcare organization (Schenschul et al., 1999). I contacted the hospital’s Nursing Research Council (Schenschul et al., 1999) to obtain permission to conduct the study. Obtaining permission was eased for me since the Council was familiar with my work, and upon presentation of my earlier study expressed desire that I conduct my dissertation there (personal communication, April 6, 2010). I presented the proposal for my dissertation to the Nursing Research Council and after approval they appointed a member to me to act as a liaison.

Sampling the nursing unit. I met with the liaison and discussed my criteria for a suitable nursing unit. The criteria, based on my prior study and the literature, included that the nursing unit had a high turnover of nursing staff, recently employed a number of new graduate nurses, was culturally diverse, was known to have nurses who engage in DB, and served patients with acute and chronic medical illnesses (Hutchinson et al., 2006a; Hutchinson, Wilkes, et al., 2010; Randle, 2003; Roche et al., 2010). The liaison suggested three nursing units, provided contact information of all the nursing managers and other pertinent healthcare workers that may be useful for the study, and general information about the hospital.

Gaining entrée to the nursing unit. Next, I approached the nursing manager of the selected nursing unit by e-mail. She immediately replied to my e-mail and immediately expressed interest in the study. A month later I met with and explained the sampling

criteria. In turn, she provided me with information about all the criteria. The nursing unit was a perfect fit for the study. I explained that I would be spending time on the unit observing the nurses as they worked, communicated, and interacted with each other. I explained that I would be as unobtrusive as possible. I also explained that I would not report any incidences of DB among the nurses to her, but if I observed patient abuse I would report it, since this was required by law. The nurse manager agreed to the study being conducted on her unit and stated that she would provide any assistance, information, and access to documents that I needed.

I attended the next unit staff meeting to introduce myself and inform all the nurses and staff members of the study and my intentions (Lofland et al., 2006). I introduced the concept of DB and provided details of consent, participation, and data collection methods to the nurses and staff to gain their support. In October 2011 the university's Institutional Review Board (IRB) approved the study. Next, I enlisted the help of the nurse manager to obtain consent from all the nurses and staff working on the unit. From December 2011 to July 2012 I immersed myself in the culture of this nursing unit.

The Nursing Unit

The setting for the study was a medical nursing unit. The unit had two long hallways running parallel to each other with short connecting hallways. Patient rooms were located along the outside of the two long hallways and in short cul-de-sac hallways at the tips of each long hallway. The unit had 22 rooms and 28 patient beds. There were 16 private rooms and 6 semi-private rooms. There were two nurses' stations, one in the center of the unit and one at the north end of the hallway. Equipment, supply, nurses' lounge, physician rooms, and restrooms were located between the two long hallways and were accessible from both sides

of the parallel hallways. One of the hallways was longer than the other, measuring approximately 300 feet long from end to end.

During the study period the unit had 64 staff members: 40 registered nurses (RNs), 16 certified nurse assistants (CNAs), five Health Unit Coordinators (HUCs, also known as unit secretaries), two Clinical Support Technicians (CSTs—staff members who can function as HUC and CNA), and one unit manager. Usually the unit also had two assistant managers, but these positions were vacant at the time of the study. The nursing staff on the unit was ethnically and racially diverse: most of the staff members were African American or Caucasian, followed by Asians, and a smaller number of Africans. Diversity also existed in terms of age (the oldest RN was 66 and youngest was 23 years old) and gender (six male RNs, and two male unit secretaries and CNAs).

The patient population on this unit had complex chronic medical conditions and was very ill. The level of staffing and nursing care for the unit was based on patient acuity and complexity. Patient acuity/complexity was based on a 1-4 scale, with 1 being a patient of low acuity/complexity, 3 the ideal patient for the unit, and 4 higher than the unit should have. A high patient acuity/complexity level (level 4) indicated that the nurses and staff had more tasks to perform with the patient and/or the patient and tasks were more time consuming than what is ideal for this type of nursing unit. The acuity/complexity level of a patient was calculated automatically via the computer documentation system when the nurses document details about their patients and patient care. The majority of patients' acuity/complexity exceeded the ideal levels most of the time. Patients often had a multitude of medical equipment (e.g., intravenous fluids, various drains, multiple dressings, and oxygen). Many patients were bedridden or dependent on the nursing staff to meet their needs of daily living.

Typically each shift was staffed with five or six nurses, a charge nurse, two to three CNAs, and unit secretary.

Patients who met certain stringent criteria (e.g., suicide risk and in a non-psychiatric unit, being behaviorally restrained, at risk for elopement, and confused and a danger to themselves) had Private Nursing Assistants (PNAs, also known as “sitters”) present in the room 24 hours a day. It was not uncommon for nine or more patients per month to require sitters (from April 2012 Behavioral/Emotional Management Report, provided by the Unit Manager).

Many patients were on isolation precautions and frequently a nurse would have three or four isolation patients in his or her assignment. Only patients on either contact or droplet isolation were accepted as the nursing unit did not have the facilities to accommodate patients on airborne isolation. Patients in isolation added to the acuity and time taken to care for them. Each time the nurse entered and exited the room isolation garments (gown, gloves, and if needed, a mask) had to be donned or removed.

Due to the nature of chronic medical diseases, some patients were frequently admitted to the unit—these patients are referred to as “frequent flyers” by the nurses (Malone, 1996). Consequently, the nurses became very familiar with these patients; however, some of the frequently admitted patients were perceived to be either non-compliant with treatment regimens or drug abusers.

Staff members in this hospital wore uniforms of distinctive color according to job title. For example, RNs wore light blue, CNAs burgundy, and pharmacy staff dark green scrub uniforms. Physicians wore either a long or short white laboratory coat depending on their status. Every staff member also wore a name tag with their first name and job title in

large letters and last name in smaller letters. This enabled healthcare workers to be easily recognizable and distinguishable from each other. I wore professional-looking street clothes and my university identification badge while doing participant observations.

A typical day on the unit. A nurse's typical day was extremely busy and complex. A typical day involved nurses, CNAs, physicians, social workers, case managers, unit secretaries, dietary, pharmacy, physical therapy, and housekeeping all working together in a shared space. Although members of the healthcare team collaborated with each other, each worked with the patients individually completing their own tasks. The nurses' shift started either at 0700 or 1900. The nurses received their patient assignment and then sought out a nurse from the previous shift to receive an oral report on each patient. Giving and receiving report was an important function and the longest time that nurses communicated with each other.

After receiving report nurses usually reviewed all the patients' documentation, especially the medication records. Next the nurses visited each patient in turn to introduce themselves and do a physical assessment. Nurses would attend to any need the patient may have at that time, for example getting a blanket, coffee, or pain medication. After the initial morning round the rest of the day would be occupied by checking when medications were due or if new medications had been ordered, administering medications to all the patients, providing patient care such as doing dressings or other medical treatments, looking for equipment or patient charts, waiting for equipment or orders, starting intravenous sites, drawing blood, doing admissions or discharges, rounding on all the patients' needs hourly and explaining procedures to them or family members, documenting in the patient's health record, making phone calls to various departments, texting physicians, collaborating with

other healthcare providers, asking other nurses for advice on procedures, helping another nurse or CNA with a task, and attending various meetings. Nurses constantly walked up and down the hallways and rarely sat down.

In addition to all the typical tasks, experienced nurses precepted new graduate nurses and nurses new to the unit for several weeks until they were ready to function independently. Student nurses from local universities and community colleges worked alongside the unit nurses and students from other disciplines (e.g., medical and pharmacology) and spent a few hours on the unit following nurses to learn their role.

Nurses experienced major interruptions during the day, for example when a patient suddenly deteriorated a “rapid response” would be called and the nurses on the unit and a designated team of specialized healthcare workers trained to deal with emergencies would rush to the patient’s room. Together they would attempt to stabilize that patient’s condition and the patient would either remain on the unit or be transferred to another unit. Psychiatric and confused patients also interrupted the nurses’ routine when their behavior demanded more time or an intervention from the nurse. Admissions from the emergency room arrived on the unit in the late afternoon, causing a flurry of activity for all the staff members at the end of shift. At 0700 or 1900 the next shift arrived and all the activities repeated.

The new graduate nurses’ day. New graduate nurses struggled to function efficiently on the unit. Due to their lack of knowledge and experience they would check their patient medication records constantly to make sure that they had administered all the medications at the right time. They would frequently question the other nurses and charge nurse about medication administration or how to do a procedure. The new graduate nurses would also question different nurses about the same thing. They also did not know what

equipment was needed for procedures and would walk to and from a patient's room several times to gather all the needed equipment. In the equipment room, they would not know where the equipment was stored or what it looked like and spent precious time looking for blood tubes, specialized needles, or dressing supplies. New graduate nurses did not know how to operate some of the equipment, for example intravenous fluid pumps and wound vacuum devices, which caused them to enter the patient's room several times until they solved a problem with the equipment. Due to the complex and very ill nature of the patient population on the unit and the inexperience of the new graduate nurses, they did not always recognize the severity of a patient's condition and therefore moved patients from the bed to a chair when they were unstable, or did not call a rapid response or consult with the charge nurse when needed.

Data Collection and Sampling of Nurses for Observation and Interviews

Conducting Participant Observation

Participant observation is the process of learning about the activities of the people under study in the natural setting through observing and participating in those activities (DeWalt & DeWalt, 2002). I spent the first few weeks of participant observation getting oriented (Schensul et al., 1999). Initially I followed nurses for about four hours at a time sequentially for 24 hours, observing the two 12-hour shifts. Observing the setting, tracking events, and examining nursing routines sequentially helped me make sense of how and when nurses interact and work in the context of their unit environment. For example, one type of activity that I tracked was communication. Over the 24-hour cycle I observed when communication among nurses was more and less intense, and how the types/topic of communication changed over time. The orientation time also allowed the nurses time to

become accustomed to me being on the unit and as time progressed I varied observation times until I blended into the unit and my presence became inconspicuous. As the nurses became used to me I progressed from strictly observing to actively participating in some activities (DeWalt & DeWalt, 2002; Schensul et al., 1999, Spradley, 1979). For example, I joined the nurses during their lunch breaks, attended unit-based meetings, and attended in-service education with them. Being seen as a group member helped me gain (a) trust, (b) access to the nurses and staff, and (c) understanding of how nurses function in their environment.

Once I became familiar with how nurses function, interact, and communicate I started to focus observations (DeWalt & DeWalt, 2002; Schensul et al., 1999, Spradley, 1979).

When I noticed a pattern of increased work activity and work load during the late afternoon I observed participants more during those hours. I would sometimes observe participants before, during, and after report time, either just sitting at the nurse's station or intermittently walking around the hallways for a few hours or following a nurse and then following the oncoming nurse. Observing at specific times of the shift provided rich data about patterns of behavior. In the mid and latter stages of data collection when I had dependable data about certain nurses and times of frequent DB, I became very systematic and selective with observational times. This strategy optimized witnessing incidents of DB.

Building Rapport

Developing a trusting relationship is extremely important when conducting participant observation; in ethnography this is known as building rapport (Schensul et al., 1999). Building rapport was essential for me to obtain rich data since this study dealt with a sensitive and emotional topic. I built rapport with the nurses and staff by using some

strategies described in the literature; for example, being sensitive to the nurses and patients, learning the nurses and staff members names, listening attentively, using professional language, learning unit customs and routines, maintaining confidentiality, participating in activities (within my limits), being helpful and unobtrusive, sharing professional knowledge, sharing some personal details, dressing appropriately, and having a sense of humor (Lofland et al., 2006; Schensul et al., 1999).

Using these strategies was eased by the fact that I was not a hospital employee, but was a nurse. Not being an employee of the hospital eased tensions as I assured nurses that I would not report any incidents of DB that I observed. Being a nurse helped me feel comfortable in the unit environment and nurses could communicate easily with me because I was familiar with medical terminology. Being a nurse was also beneficial as the nurses and I had a common thread that connected us. I was very honest with the nurses at all times, especially when they asked me to help them with patient care. I reminded them that I was there in a researcher role to observe and that they need to proceed as they normally would. To maintain good rapport and reciprocate the relationship I did help them with tasks such as getting a blanket or a spoon if the nurse needed it (Schensul et al., 1999; Spradley, 1979).

I felt particularly trusted and part of the group when nurses included me in the circle of conversation when talking about their lives, telling jokes, or joking with me. I also felt trusted when nurses sought me out and confided in me their workplace and personal difficulties. Slowly a pattern of body language developed between me and the nurses. For example, when I observed report at change of shift and a nurse experienced DB, the victim nurse would look over and make eye contact with me and after ending their conversation

with the disruptive nurse walk by me staring directly in my eyes and tensing their facial muscles. I interpreted this as a “did you see what just happened?” look.

As rapport developed nurses started slowly, then constantly, telling me about DB. The nurses became very explicit in reporting recent DB events, disclosing information about nurses engaging in DB, and even providing me with copies of their written complaints of DB to the manager or human resource department, texts which enriched my data immensely. The trust that I developed through building rapport helped me identify key informants.

Key informants were individuals who had excellent knowledge of the setting and phenomenon being researched (Schensul et al., 1999; Spradley, 1979). I connected with one nurse immediately on the day I introduced my study to the unit. This nurse recognized me from my earlier pilot study and she offered her assistance. She was very familiar with the unit, having worked there for many years, and was also very familiar with DB occurring on the unit over the years, experiencing and witnessing it on multiple occasions. She helped by providing me with valuable information about the nurses and unit throughout my months on the unit. To ensure that I gathered data from multiple perspectives for cross-checking, credibility, and trustworthiness I built dependable relationships with three other nurses of varied gender, race, and experience level who also became key informants. Together, they provided a deeper level of data on the same topic from different perspectives of nursing experience, gender, and race (Charmaz, 2006; Schensul et al., 1999).

Strategies that I used to develop and maintain relationships with my key informants included spending more time with them during participant observation, always engaging in conversation with them when I was on the unit, and seeking them out when I visited the nursing unit after I concluded data collection.

I concluded participant observation activities after spending six months on the unit. No new data about disruptive behavior and the nurses who initiated and experienced it was forthcoming and I realized that data saturation (Schensul et al., 1999) had been reached. I had also witnessed multiple DB events at that point. I continued to visit the unit for several months to maintain a presence and to collect data about events and changes on the unit, perform some fact checking, and to verify ideas that I developed during data analysis (Charmaz, 2006; Schensul et al., 1999).

Sampling Nurses for Participant Observation

At first I convenience sampled nurses for participant observation so that I could get to know them and the unit routine. At first, when I arrived on the unit I would ask any nurse I saw if I could follow them as they did their work for a few hours. As time progressed and I heard about and witnessed DB, I changed to purposive sampling. Purposive sampling refers to selecting nurses based on their actual and direct experience with a phenomenon (Spradley, 1979). I would look on the unit work schedule to see when specific nurses were working, come in on those days, and ask if I could do participant observation with them. This provided me with an opportunity to talk to them about the incident or ask them for an interview. I conducted participant observations with 22 nurses. Nineteen were female and three were male; 11 were Caucasian, four were African American, three were African, and two were Asian. Five were new graduate nurses and two nurses were experienced, but new to the hospital and the unit.

Sampling Nurses for Interviews

During participant observations I became very familiar with the nurses on the unit, which helped me recruit nurses for interviews. After about three months of participant

observations I began purposive sampling of nurses for interviews (Spradley, 1979). I interviewed 16 unit nurses. Thirteen nurses were female and three were male, five were new graduates, and 11 were experienced nurses. Ten nurses were Caucasian, three were Asian, two African American, and one was African. I interviewed my key informants first since they all had experienced DB on the unit, and freely shared information about nurses who initiated and had experienced DB. They also provided me with copies of their written complaints about disruptive events. I used the information provided by the key informants to recruit more nurses for interviews. When I observed incidents of DB on the unit, if possible, I recruited the victim nurses and nurses who witnessed the event for interviews. Additionally, during interviews several nurses would tell me about the same DB incident; again I tried to interview all the nurses who were involved or witnessed the incident to obtain information from multiple perspectives.

In addition to the nurses, I also interviewed the nurse manager and a long-time unit secretary to gain their perspectives. Nurses mentioned the Human Resources Department and the Clinical Educator often in their interviews, so I arranged to meet and have a conversation with the New Graduate Coordinator and a representative from the Human Resources Department. The New Graduate Coordinator met with the new graduate nurses monthly and was responsible for their transition to the units and hospital. The representative from the Human Resources Department dealt with complaints about DB hospital-wide.

Conducting Interviews

Semi-structured interviews were ideal for the study because they were face-to-face and took place in a setting where the nurse and I could sit down and have a conversation in private without interruption (Kvale & Brinkmann, 2009; Spradley, 1979). I followed

interview strategies provided by Charmaz (2006) and Spradley (1979) to gather data. I met with nurses in a place of their choosing, for example my office, their home, a park, or a coffee shop. I explained the consent and audio-recording device and after signing consent I started the interview with a broad sweeping question about their experience with DB. I followed with probing, clarifying, interpreting, and other types of questions to obtain detailed data when possible. Nurses were eager to talk about DB and as the reader will see in my description of the interview data (next), I did not always get the opportunity to ask many questions.

Data Management

The Data

I engaged in participant observation 44 times or for 140 hours over a 6-month period of time. There were 343 pages of field note data, typed double spaced. I interviewed 16 nurses, one HUC, and the unit manager. Interviews lasted from 50 to 150 minutes and totaled 21 hours and 18 minutes. After transcription I had 538 double spaced typed pages of interview data. I spoke on average 12% of the time during the interviews, with the most 20% and the least 4%. To provide depth and context I had two unrecorded conversations; one with the New Graduate Coordinator and one with a representative from the Human Resources department. I also collected contextual documents (e.g., workplace policies, copies of letters of complaints from the nurses).

Field Notes

Initially, during early participant observations, I did not take notes in the presence of the nurses. I did not want to raise suspicion among the nurses and it made me feel uncomfortable to take notes in their presence (Schensul et al., 1999). I retreated to the

bathroom, equipment room, or staircase to quickly jot down key words when I had the opportunity. I made mental notes and repeated constantly in my mind what I saw and heard. When I left the unit I rushed to my car and expanded on my limited notes and jotted down everything I remembered. As I adjusted and became more comfortable, I started carrying a pencil and paper openly with me and took notes in the nurses' presence (Schensul et al., 1999). When I arrived home I immediately typed up my notes remembering my time on the unit like a movie in my head. I also made a short summary of each field note and noted the number of nurses and staff on shift (Bernard & Ryan, 2010; Schensul et al., 1999). Field notes varied from seven to 12 double spaced pages in length and took me about two to four hours to type.

Interviews

I interviewed each nurse at their setting of choice. Settings varied from the interviewee's home to my office space to booths at local coffee shops. At the start of the interview (when I was able) I introduced the study and obtained informed consent (Kvale & Brinkmann, 2009; Roulston, deMarris, & Lewis, 2003). In most cases the nurses started talking as soon as or even before we were seated. On several occasions I could only point to the consent form and audio recorder and the interviewee would sign and nod their head toward the recorder while they were talking and telling me about DB. In the beginning I was troubled because I could not ask the questions that I prepared and I tried to redirect the conversation with a follow-up question, but they would either ignore the question or superficially answer it before continuing with their original train of thought. I soon realized that the nurses wanted and needed to talk about their experiences in their own way and that the nature of qualitative research and interviewing is open, fluid, and flexible, so I let the

nurses relate their stories without redirection, but with follow-up and clarification at the end of the interview (Charmaz, 2006; Kvale & Brinkmann, 2009).

Most nurses stated afterward that they felt much better and they were happy that someone was taking an interest in their problems (Corbin & Morse, 2003; Dewalt & Dewalt, 2002; Esposito, 2005). I transcribed all the interviews within 24-48 hours. Each hour of interview took me approximately three and half to four hours to transcribe. I made a short summary of each interview and included basic demographic information about each interviewee (Bernard & Ryan, 2010).

Protection of Participants

I protected the confidentiality of my participants by assigning each a pseudonym. I kept the log matching the participant to their pseudonym separate and secure from all other data. I never used any names in my rough field notes and used the pseudonyms when I transcribed the data in the computer. During interviews I asked the interviewee not to use any names, and when they did I deleted it from the audio recordings. After transferring the audio recording to my computer, I deleted it from the recorder. All computer files that I created and data in the software program was password protected and stored on my academic institution's secure computer drive. All contextual documents (e.g., policies) that I obtained were acquired with permission of the hospital's Nursing Research Council and the unit manager and were kept secure. I also collected copies of letters relaying nurses' reporting of DB to the manager and rebuttal letters when complaints were made—the nurses spontaneously offered these documents to me.

Data Analysis and Synthesis

To store and organize the data I used a qualitative software program (NVivo 10). The program also provided for the management of codes, annotations, memos, and personal reflections.

The grounded theory analysis approach is systematic and pragmatic, yet at the same time is flexible and iterative (Charmaz, 2006). Congruent with a grounded theory approach I wanted my analysis to be grounded in the data and my interpretation, insights, or claims that I made fit the data (Charmaz, 2006; Milliken & Schreiber, 2001). Simultaneously, my objective was to answer the research questions.

Analysis and synthesis of the data was a complex and multi-layered process with several activities happening simultaneously (Bernard & Ryan, 2010; Charmaz, 2006). Inherently, a rough comparison of data and identification of main ideas started during the process of reading through and summarizing each individual interview and field note. I started or added to memos or made notes of striking thoughts and insights throughout the data collection phase. In addition, I was able to identify important cues and gaps in my data which allowed me to adjust my research plan, interview questions, and participant observations.

Coding and Categorizing

As I transcribed field notes and interviews certain data repeated and therefore stood out. Initially I coded sentence-by-sentence but found that this resulted in an overwhelming number of codes (Charmaz, 2006). After consulting with my dissertation chair and several attempts at different ways of coding, I found that coding according to the action described in a paragraph worked ideally. For example, as nurses told me their stories of DB, most

included a sequence of information (e.g., who, behaviors, feelings). After initial coding I progressed to focused coding by carefully considering the most frequent and significant codes (Charmaz, 2006). I restudied those parts of the data to evaluate the importance of these data to the nurses and how they fit with my research questions. My evaluation included comparing codes and data with each other. In the process, I made sure that my preconceptions and biases did not influence the study. Next, I condensed and clustered similar codes together and formed categories, for example: *antecedents*, *characteristics of behaviors*, and *consequences of behaviors*. Within each category I created subcategories. I tried to be as meticulous as I could when creating subcategories and evaluated carefully how each subcategory fit with the main category by reading and comparing the data and making tables. When creating subcategories for example, in *antecedents* I subcategorized data that the nurses believed led to DB (e.g., nurses involved, unit factors). In *consequences of behaviors* I created subcategories such as reporting DB and emotions. Field notes provided different codes which led to categories such as *people*, *places*, *nursing actions*, and *interactions*. In the category *people* I listed the staff and nurses of the unit (using pseudonyms) and I placed data, memos, or notes associated with a specific person in their own subcategory. I also paid attention to nurses' language and made NVivo codes, for example, *this is our drama* and *walking on eggshells*. Since I spent time on the nursing unit and developed close relationships with the nurses I also created other codes for events or data that interested me. One such example is a code called *special stories* where I placed data of stories that nurses told me that were not directly about DB.

Exploring and Comparing Codes and Categories

To explore and better understand how DB occurred on the unit I made several diagrams based on the codes or embedded in a category representing the sequence or process. When I met with my dissertation chair we often developed these further or made new diagrams that clarified what was occurring on the nursing unit or how nurses reacted to DB (see Chapter 4).

Comparison between data, observations, incidents, codes, and categories was a core activity that took place throughout the data analysis. This process started early in data collection and gained momentum as the study progressed. During transcription of field notes and interviews I recognized similar words and meanings and I made notes of which nurses spoke about similar things and which relayed something different. As I explored these similarities and differences I used NVivo's word trees, matrices, and tables to help visualize data (see Appendixes E and F). I also made notes by hand and used colored post-it notes on printed interviews and field notes. Comparing, scrutinizing, thinking, and talking about the similarities and differences in the data with my dissertation chair thoroughly enhanced my conceptual understanding of categories and helped me shape my ideas and understanding of DB.

Memo Writing and Reflection

Memo writing and reflection brought transparency to the process of how I analyzed, acted on the data, discovered threads, linked ideas, and decided what was significant (Burns et al., 2010; Charmaz, 2006; Watt, 2007). In my experience of conducting the study, these two processes went hand-in-hand and overlapped at times. I tried to focus memos on the data and reflected on my personal experiences and thoughts. For example, I created a memo

called *Events* where I wrote and developed ideas about DB events that I witnessed during participant observation. As the study progressed and I started conducting interviews the memo grew and morphed as I developed ideas, clarified my coding, and spelled out details. In my reflections I examined my assumptions and thoughts about the events. In a memo called *Reporting Issues* I examined and developed ideas about the nurses' lack of knowledge related to reporting DB and explored the reporting procedure. I also wrote a memo about the research process and coding of data, titled *Coding*. This memo was a mix of what I did and the emotions that I experienced. Writing memos and reflections helped me not only discover the core processes at work, patterns of behavior, and condensed meanings, but also helped me to deal with the emotional toll of the study.

Although I analyzed the data and wrote memos throughout, further analysis and in-depth exploration of the data took place when I combined the dissertation chapters. I started with an abundance of very detailed writing which I soon realized was too much. During the time when I developed the chapters and struggled to refine and focus my categories into a readable state, I experienced major personal changes which caused me to set the study down for a few months. On reflection, the time away from the data was beneficial and when I returned to writing I could see the data more clearly and objectively. Previously I wanted to hold on to many details, but now I was focused and sought out the most compelling data. Through writing, rewriting, and editing, the story of DB and the struggles of the nurses came forth.

Contextual Documents

I collected standard policies and procedural documents related to the hospital's vision and mission and Code of Conduct requirements (see Appendix G). I obtained all the

pertinent policies on peer evaluation and workplace violence, reporting, and corrective action. In addition, nurses provided me with copies of letters and e-mails of complaints of DB and rebuttal exchanges. Lastly, the nurse manager provided me with statistical information and spreadsheets about patient acuity and complexity, behavioral/emotional management, daily and monthly patient census, and employee turnover.

I did not code or categorize the documents, but I examined each document in terms of their specific purpose within the organizational and cultural context of the hospital and nursing unit. I incorporated the pertinent documents in my findings.

Issues of Trustworthiness

Trustworthiness refers to the quality of qualitative research (Charmaz, 2006; Mackey, 2007). Credibility is the most important and extensively used criterion to evaluate qualitative research (Charmaz, 2006; Wuest, 2007). To ensure credibility of this study, I discussed in detail how I gained entrée to the healthcare facility and the unit. I described extensively how I gathered data and observed nurses on the unit. I analyzed the data systematically through coding, developing categories, and comparing data by making tables and diagrams. Furthermore, I used multiple methods of data collection enabling triangulation of data. During interviews when discussing certain DB events, nurses would say: “you were there, you saw what happened.” I engaged in member checks, for example when I noted a pattern of behavior I asked several nurses about the pattern. From the start of the study until long after data collection was completed I did memo writing and reflected on the process. Lastly, to enhance trustworthiness and credibility I worked closely with my dissertation chair to talk through and clarify my data.

Dependability is closely related to credibility and refers to the transparency of the processes and procedures used to conduct the study and analyze the data (Wolf, 2007). To ensure dependability I provided detailed and thorough explanations of how the data were collected and analyzed.

It is important for me that the results of this research are used in the future and that the study contributes to nurses' understanding of the problem. To facilitate transferability I provided rich description as a means to communicate to the reader a realistic and comprehensive picture of DB and detailed information about the background, conditions, and context of nurses' experiences and work environment. The reader of the study can assess if similar processes are at work in their own setting by understanding how they occurred at the research site. I would also argue that this study is original in its research approach and offers new insights and conceptual renderings of the phenomenon of DB.

Summary

In summary, this chapter described my research methodology—a qualitative study using participant observation and semi-structured interviews as data collection methods. I described in detail how I gained entrée to the health care facility and sampled a nursing unit with the help of a liaison. After IRB approval for the study I gained entry to the nursing unit where I first started with participant observation and then started doing interviews. I explained what the nursing unit looked like; who the nurses, staff, and patients were; and I provided a rendition of a typical day on the unit for an experienced and new nurse.

I spent six months collecting data on the unit, conducting participant observations 44 times and interviewing 16 nurses and four other pertinent healthcare workers. I described what the data looked like and how I managed it primarily by using a software program. The

grounded theory techniques that I used for data analysis included coding and categorizing, and comparison of codes and categories by making notes, tables, and matrices. To explore sequences of events and processes at play my advisor and I made diagrams. I also wrote memo's and reflect. I concluded the chapter by discussing issues of trustworthiness.

CHAPTER IV

FINDINGS

The purpose of this study was to explore disruptive behavior (DB) from the nurses' perspective, the contexts and circumstances under which it occurs, and to understand the process of DB among nurses working in one healthcare setting. In this chapter I present the findings starting with an exemplar of DB. The exemplar demonstrates the occurrence of DB in the context of the work environment as explained in the previous chapter. I continue by presenting the characteristics of DB including the actors, actions, and responses to the actions. Next, I describe the never-ending nature of DB on the nursing unit. Lastly, I summarize the chapter. The findings reflect the integration of data from interviews, participant observation, and contextual documents.

Kelly's Story

Kelly, a new graduate nurse, felt anxious. It was the end of shift and she had to give a report to Sabrina, an experienced nurse known among co-workers for her volatile behavior. Kelly had been rushing to finish caring for her patients and was still busy completing the documentation and care of a newly-admitted patient that she received from the Emergency Room at 1830 hours just before change of shift at 1900 hours.

During the change-of-shift report at the nurse's station, Sabrina questioned Kelly about every detail of each patient's medications and treatments. As she questioned Kelly, Sabrina's voice became louder and Kelly, not being able to supply all the answers as to why

a physician prescribed a specific medication, became increasingly flustered. Sabrina repeatedly stabbed her index finger at the medication administration record (MAR) of the new patient and said loudly that Kelly had made a medication error. Kelly tried to defend herself, saying that she did not make an error, but Sabrina stood up and shouted loudly over and over: *“YOU MADE AN ERROR! YOU MADE AN ERROR!”*

The other nurses stopped talking, looked in the direction of the commotion, and then resumed their conversations. Kelly could feel her heart pounding and her cheeks getting hot. Kelly was responsible for copying the medication name, dosage, and times they were due from the physician’s orders into her new patient’s MAR. Kelly transcribed all the medication names but only included the due times applicable to her and omitted the times due for other shifts, including Sabrina’s. When Sabrina quieted down, Kelly took the MAR and said that she would add all the medication times for the night shift. Continuing in a loud voice, Sabrina told Kelly that she needed to complete all the nursing care and documentation on the new patient before she went home. Responsibility for nursing care and associated documentation for late patient arrivals should be passed along to Sabrina on the night shift per policy, but Kelly, later saying she felt intimidated and nervous, did not say anything. Instead, Kelly stayed late, finished the admission documentation and started a new intravenous infusion, set up a tube feeding on that same patient, and went home an hour after her shift ended.

The Characteristics of Disruptive Behavior: “...This is Our Drama...”

DB presented itself as a complex phenomenon and was a regular occurrence on the nursing unit. Although most of the nurses on the unit showed some sparks of DB during the study, the focus of this dissertation was on recurrent DB, initiated either by nurses who had a

pattern of constantly being disruptive or nurses who initiated DB under stressful situations. These DB behaviors included a variety of verbal and physical actions occurring in private or public places on the unit. A DB event elicited many responses that involved managing DB, recovering from DB, and preparing DB.

The Actors

Two categories of nurses initiated DB regularly on the nursing unit: disruptive nurses (individuals who had a pattern of continual DB) and stress-reactive nurses (individuals who initiated DB only under stressful circumstances). Eight of the interviewed nurses and three nurses during participant observation described characteristics of and named specific nurses on the unit who had a pattern of continual DB. Two of the three disruptive nurses were experienced and one was a new graduate nurse. The disruptive nurses were typically described as having certain “personalities.” For the nurses, the term “personality” referred to enduring patterns of disruptive behavior that they experienced from these nurses (adapted from APA, 2013). Beverly said: “you can’t change them...we have all these personalities, strong personalities, they are so volatile... “Their behaviors were verbal and physical, forceful, distinctive, and typically included speaking very loudly, acting in an authoritarian manner, advancing their own self-importance, lacking empathy, and never being repentant or receptive to seeing a situation from another point of view. Alice, talking about one of the disruptive nurses said: “she will try and suck you in to all sorts of conflict and it when you react she enjoys it – she feeds off the reaction.”

When the disruptive nurses initiated DB, it was theatrical, all or most of the nurses were aware of the event and the effects thereof tended to be prolonged. Darla said: “I know that anything can set them off, they are really loud and aggressive... and the behavior is out

of proportion, crazy....” Alice, talking about one of the disruptive nurses said: “if she is angry with you everyone will know because that will be spread out – she will just spread that information to everybody and try to turn everybody against whoever she is upset with.” Geraldine said: “They will make things huge, even if it was a small issue they did not agree with.”

The most disruptive nurse had been working on the unit for more than 10 years. She had a significant effect on the nurses, was offered as an example in almost every interview, and dominated their thoughts at work and at home. For example, when I asked for other examples of nurses engaging in DB, Rowena stated: “. . . Sabrina dominates my thoughts and examples.” When Sabrina was scheduled to work, the nursing staff anticipated DB and new nurses especially feared her.

The second most disruptive nurse was typically described as “a drama queen.” She used more physical behaviors than the other nurses. Behaviors such as hand gestures, pushing, shoving, and invading personal space to the point of near physical attack was more typical than not. The third disruptive nurse—a new graduate—was a less frequent offender. Her behavior was viewed by the nurses as “a coping mechanism” and/or “(being) insecure.” Even though this nurse’s DB was not as severe, four nurses described being around her as tense and Alice said it was like “walking on eggshells.” Nurses spoke most about the two experienced nurses and less about the new nurse.

The second category of DB nurses was of those who were stress-reactive. Almost all of the nurses were capable of lashing out under stress, but three nurses on the unit had a pattern of stress-reactivity. Their behavior was verbal in nature and anticipated by the other nurses under certain circumstances. The DB of the stress-reactive nurse was different from

the disruptive nurse because it was brief, less intense, and typically included behaviors such as talking fast, giving short answers, being irritable, and having a sharp tone of voice.

Rhonda said: “Do you know Carol? She is very nice, but when she is under stress—don’t even talk to her, because she will snap at you—I mean that’s her way. Like—during a code . . .” Katrina, talking about a stress-reactive nurse said: “she is just a little cynical and a little huffy, but she is still very nice and has a good heart.” In interviews with the stress-reactive nurses, two nurses acknowledged their behavior. For example; one nurse, Beverly said: “I get anxious, it’s so overwhelming, and I get frustrated...I know I get out of line, but they [the nurses] know me ...and I always apologize afterward.” Although stress-reactive nurses’ behavior troubled the nurses, their behavior caused less anguish and suffering than the disruptive nurses’ behavior.

When DB Was Most Likely to Occur

Table 1 illustrates the two nurse categories and the intensity of DB occurring by situation.

Table 1

Intensity of DB Occurring Based on Context and Circumstance

Nurse	Experiencing High stress	Receiving Report at Change of Shift	Normal Unit activity
Disruptive nurse	HI	HI	HI
Stress-reactive nurse	LO	LO	N/A

Note. LO = low intensity DB (e.g., snide comment, sharp tone of voice); HI = high intensity DB (e.g., yelling, being condescending, shoving)

Disruptive nurses initiated DB at any time during a shift. The intensity of behavior was always high for the disruptive nurses. Voices were loud, body language exaggerated, and many people were involved or witnesses. Events were theatrical and most of the nurses and

staff on the unit would be aware that a disruptive event had occurred. Stress-reactive nurses initiated DB only during times when they perceived stress, for example during high stress situations (patient deteriorating) or during change of shift report. During the rest of the shift when the nurses did not perceive stress they did not initiate DB. The intensity of their DB was low and confined to the person they were speaking to and at times, the nurses in the immediate vicinity.

Experiencing High Stress

While high stress and receiving reports are parts of the ebb and flow of normal unit activities, but I highlighted these times because these activities increased the likelihood of DB occurring. Both the disruptive and stress-reactive nurse initiated DB when experiencing times of high stress and during change of shift report, while only the disruptive nurse would be more likely to initiate DB at other times.

Examples of high-stress events included caring for multiple patients who were very ill with multiple complex tasks to complete, receiving an admission at end of shift, doing several tasks under strict time constraints, constant phone calls, or having a patient deteriorate rapidly (cardiac or respiratory arrest or seizure). Ella gave a perfect example of experiencing a high stress time period when she said: “there was one day—I had to discharge four patients—all of them in 30 minutes and I got two admissions and two transfers in at the same time.”

While both the stress-reactive and disruptive nurses initiated DB under stressful conditions, the disruptive nurses’ behavior tended to be more severe compared to the stress-reactive nurses’ behavior. Disruptive nurses’ incidents typically involved more than one nurse and/or other healthcare workers. For example, other unit workers (e.g., unit CNA and

secretary) did not escape DB and came under attack when information was not exchanged timely enough for the disruptive nurse. These incidents had become commonplace, and while most were limited to being reported to the unit manager, a small number escalated into major events, one causing the CNA to leave the unit. DB events that only involved the unit nurses caused a mixture of reactions, complaints, and consequences, which I discuss in the next segment of this chapter.

In contrast, some DB events that included other healthcare workers (e.g., physicians) caused major ripple effects. Four nurses described two separate events when disruptive nurses yelled at several nurses, physicians, pharmacists, and information technology staff. Both events caused immediate reactions and formal complaints by the persons involved, and hospital administrators and the human resources department had to step in to resolve the issue.

The stress-reactive nurses' behavior during times of high stress was short lived and involved only the other nurses. For example, one day a nurse, Susan, had a complex and time-consuming discharge. While dealing with the discharge, Susan was interrupted multiple times by phone and patient calls. Susan was breathing hard, making grunting noises, swearing softly under her breath, walking and writing rapidly, and handling papers in a flustered way. When the charge nurse offered help, Susan addressed the charge nurse in a short, sharp tone of voice, and said that she would "deal with it." The charge nurse did not approach her again, indicating a breakdown in communication on the unit, possibly impeding patient care.

Receiving Report at Change of Shift

The majority of DB on the unit occurred during change of shift report. The vast majority of nurses performed this activity at the nurse's stations, which are central areas of activity where computers, phones, copiers, desks, the HUC, charge nurse, patient charts, medication records, and so forth are located. During change of shift report time (approximately 0700–0730 and 1900–1930) on-coming and off-going nurses stand or sit close together and talk for several minutes about a patient. The off-going nurse does most of the talking, telling the on-coming nurse about the patient, what was done, and what needs to be done. The on-coming nurse intermittently asks questions. Although there is an expectation of passing along care and tasks from one shift to the other, unwritten rules and expectations exist among the day and night shift of what should be done by each shift. A typical example occurred one morning when a stress-reactive nurse raised her voice and questioned the night nurse in very short, clipped sentences about medications due every two hours for a patient and a missing sputum sample of another patient. The stress-reactive nurse made a blowing sound through her nose and complained loudly about administering medications frequently and tracking down a missing specimen when she already had a busy patient assignment.

The two experienced disruptive nurses were especially active during report time. Although they were indiscriminate about whom they attacked, they particularly targeted the new nurses during report. Steve and Geraldine commented: “the new nurses, oh she will make them cry . . .,” and “she attacks the new nurses . . .” The new nurses felt unsure and vulnerable. Ella, a new graduate nurse said: “I dread giving report to them . . . so I take a deep breath and do my best.” Kelly said:

I get anxious, it is hard enough as it is being a new nurse without having the people who have experience making you feel even worse . . . but rather [you want them] recognizing that it [the unit] is a vulnerable place to be.

Three nurses believed that the disruptive nurses would come to work early for the purpose of finding mistakes. Steve said that they were “looking for someone to pick on.” The most disruptive nurse especially was observed by the others studying the patient’s documentation ahead of time. The nurses suggested that this pre-shift activity was done in order to question the nurse giving report extensively about the patient’s history, physician orders, every test, and results. If the nurse was not able to answer the questions to their satisfaction, they would initiate DB. Ella provided an example:

. . . they want every little detail, every specific, thing like their H & P [History and Physical of patient] and sometimes during the day you don’t get to look into all those details, so when they ask you about it and you don’t have that information for them they will be like . . . YOU DON’T HAVE THIS!?

As a reaction to the pattern of DB targeted at the new nurses, some of the nurse mentors would endeavor to protect the new nurses. The nurse mentors used strategies such as warning the new nurses about the disruptive nurses, giving report to the disruptive nurses for as long as the new nurse was under mentorship, and helping the new nurse devise an approach to give report to a disruptive nurse. All of these protective efforts served to keep the unit running smoothly and shield the new nurses from the trauma of experiencing DB.

Normal Unit Activity

DB also occurred during the hustle and bustle of the rest of the shift when patient care activities occurred. The disruptive nurses, especially the most disruptive nurse, initiated DB at any time during shift. Mostly, the DB behavior was associated with a patient or work-related issue, for example receiving a new admission midway through a shift, receiving several new orders for a patient from a physician, disagreeing with another nurse’s work

method, and asking for help from another nurse and not receiving it. One day, a disruptive nurse shouted so loudly at a new nurse in the hallway about the amount of time she took at the medication dispensing cart to get her patient's medications that it could be heard 40 feet away.

Overall, compared to the impact of the behavior of the disruptive nurses, the unit nurses did not consider the stress-reactive nurses' behavior to be as severe or significant.

What DB Looked Like

The majority of DB on the unit was a mix of verbal, physical, and indirect or in-absentia behaviors. The most prevalent verbal behaviors included screaming, critical questioning, criticizing, belittling, complaining, judging, and threatening. The Kelly story illustrates shouting and critical questioning. Alice provided another example when she said: "she [disruptive nurse] was screaming at me down the hallway 'you need to come here and talk to me right now.'" Steve said: "she [disruptive nurse] will make a remark and the physician is sitting right there—very derogatory remarks . . . [imitating her] 'I don't know where they went to medical school.'"

Physical behaviors included hand and arm gestures (finger pointing, stabbing at papers with finger, slamming fist, moving arms in exaggerated way), walking in an aggressive way (walking fast, pumping arms, looking straight ahead, not giving way to other people), invasion of personal space and pushing, among many others. Beverly told me about an event during report: "she was sitting next to me, to my right, and she literally pushed her arm over me pulled the mouse out of my hand." Darla said one day she and a disruptive nurse had an argument: "she put her hand in my face—she had her hand like this [holding her hand in front of her face]—an inch away from my face and she of course denied it." One

day, during a cardiac arrest (code) situation, a disruptive nurse rushed into the patient's room, put her hands on the waist of a nurse who was doing chest compressions, physically lifted and pushed her off the patient, and said loudly that she would do the compressions. The victim nurse later told me: "I thought I was doing a good job."

A third type of DB behavior was indirect or in-absentia and included spreading gossip, back stabbing, and avoidance. One example is complaining loudly to all the nurses at the nurse's station about how the nurse on the previous shift incorrectly set up suction equipment in a patient's room. As another example, Charlotte, a nurse who came to work on the unit with the specific purpose of doing admissions at odd hours of the night and did not have a typical patient work assignment, told me about a long and sustained DB event. After being involved in a prior DB event with a disruptive nurse, Charlotte heard rumors that the disruptive nurse was spreading gossip that she was lazy, not doing her work properly, and taking advantage of her position. After confirming the rumor, Charlotte confronted the disruptive nurse. She denied the allegation, then did not speak to and avoided Charlotte for two months. Charlotte referred to this behavior as "the silent treatment."

Where DB Occurs: Private and Public Areas

DB on the nursing unit either occurred in (a) private spaces; (b) public spaces; or progressed from (c) private to public spaces, or (d) from public to private places. Private DB refers to the event occurring between two nurses in a private area where others were not present, for example the staff or locker room, medication cart, or in an empty hallway. Lanie stated: "I had gone to get something out of my locker and Sabrina followed me into the locker room—so it was just her and I . . . I am cornered in the locker room by myself."

Nurses also relayed many stories of DB events occurring in the hallways with no one else in the vicinity, typically stating: “She cornered me in the hallway . . .”

Public DB refers to DB occurring in the presence of patients, visitors, other nurses, or healthcare workers. Public DB can be directed at one person (e.g., during report at the nurse’s station—as illustrated in the Kelly example), with nurses and other healthcare workers able to witness the event. Sometimes public displays involved no one in particular, but entailed the disruptive complaining at the nurse’s station, or while walking down or standing in the hallway.

There might be a flow of negative comments and complaints about the workplace or some work situation. Everyone in audible range was subject to the stream of negative comments. While on the unit one evening, there was an event where one nurse did not agree with the type of patient (suicidal patient) that was admitted to the unit. For about half an hour, she walked up and down the hallways talking and stopping several times at the nurse’s stations saying over and over to no one in particular that the patient should never have been admitted to this unit. Even as an observer, I found my muscles tensing, heart rate increasing, and trying to avoid this nurse.

In some cases the behavior can seem nonspecific, but others know it is being directed toward one person. For example, a nurse might repeatedly complain about a work issue when in the same area as the charge nurse (immediate supervisor) for the shift. Derek (charge nurse), after assigning a patient admission to a disruptive nurse, said: “. . . you could hear her screaming from one end of the hallway, screaming about the injustice of it all . . .” The nurses experiencing and witnessing this felt they had to cope with an emotional burden that added unnecessary stress to their already stressful workload. Samantha said “I feel

defensive, like I am being blamed . . . judged. We don't need this, it is so discouraging.” Rowena, as if talking to one of the nurses who did this, said: “I don't want to be your . . . where you just drop off all your garbage and leave and then it is left with me . . . it is almost like one person takes a whole lot more of your energy.”

DB also moved from private to public areas and from public areas to private areas. Four nurses told me about a recent altercation between two nurses that started in private in the staff room and then progressed loudly up the hallway and to the nurse's station where it then simmered down. On the other hand, one evening there was an event that started out at the nurse's station; when the one nurse started to walk down the hallway, the disruptive nurse followed her and the conflict continued down the empty hallway. One of the nurses watching the event with me said: “Now she is going to be chewed out around the corner.”

The Consequences of a DB Event: How Unit Nurses Respond

Asking nurses to tell me about a disruptive incident almost always elicited a pattern of events related to a disruptive nurse and rarely about the stress-reactive nurse. A DB event created a ripple of emotional and behavioral consequences for the nurses.

Initially as the event was occurring, there was shock and disbelief. Ellen said that when the nurse raised her voice, “I could not believe it!! I thought—What!!” Victim nurses reported a range of emotions including fear, anger, anxiety, guilt, and/or shame. Charles told me how he felt during a DB event in a patient room: “I was so offended, in my mind I was saying oh my God—now imagine what that patient is thinking—this nurse [Charles] who was taking care of me didn't know what he was doing.” After an event Katrina said: “I just feel guilty and [as if] these nurses hate me.” The consequences of DB were not only immediate, but also generated long-term responses. The consequences of events carried over

into the personal lives of the nurses, and the nurses even prepared for future encounters with the disruptive nurses. Coping measures when DB occurred during the shift or at end of shift were similar and included efforts to manage, recover, and prepare for future events.

Figures 1 and 2 demonstrate the sequence of reactions and consequences when the event happened at the end of shift and during a shift. The figures start with the disruptive event and the arrows indicate the sequence of reactions. The broken arrow lines in the figures indicate that there may or may not be a DB event the next time the two nurses meet.

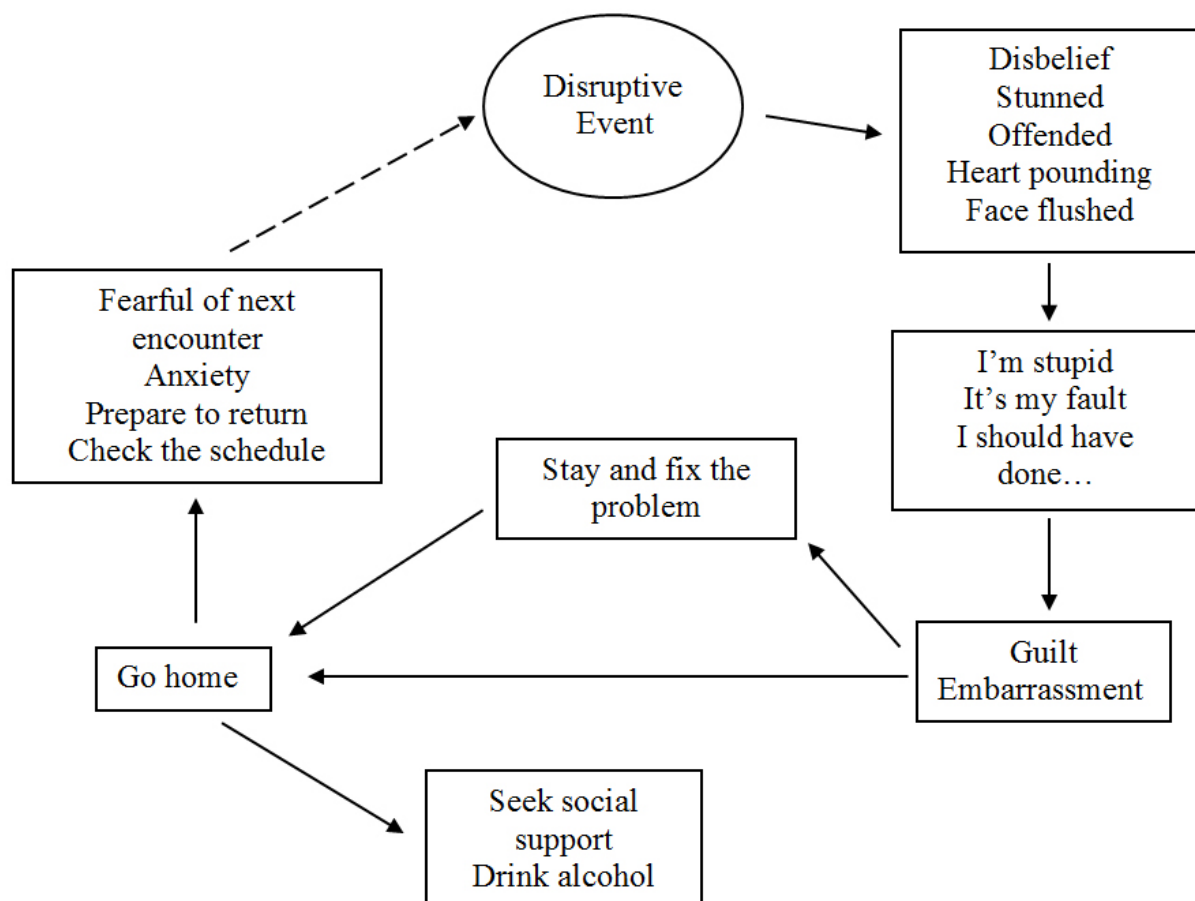


Figure 1. The consequences of DB at the end of shift.

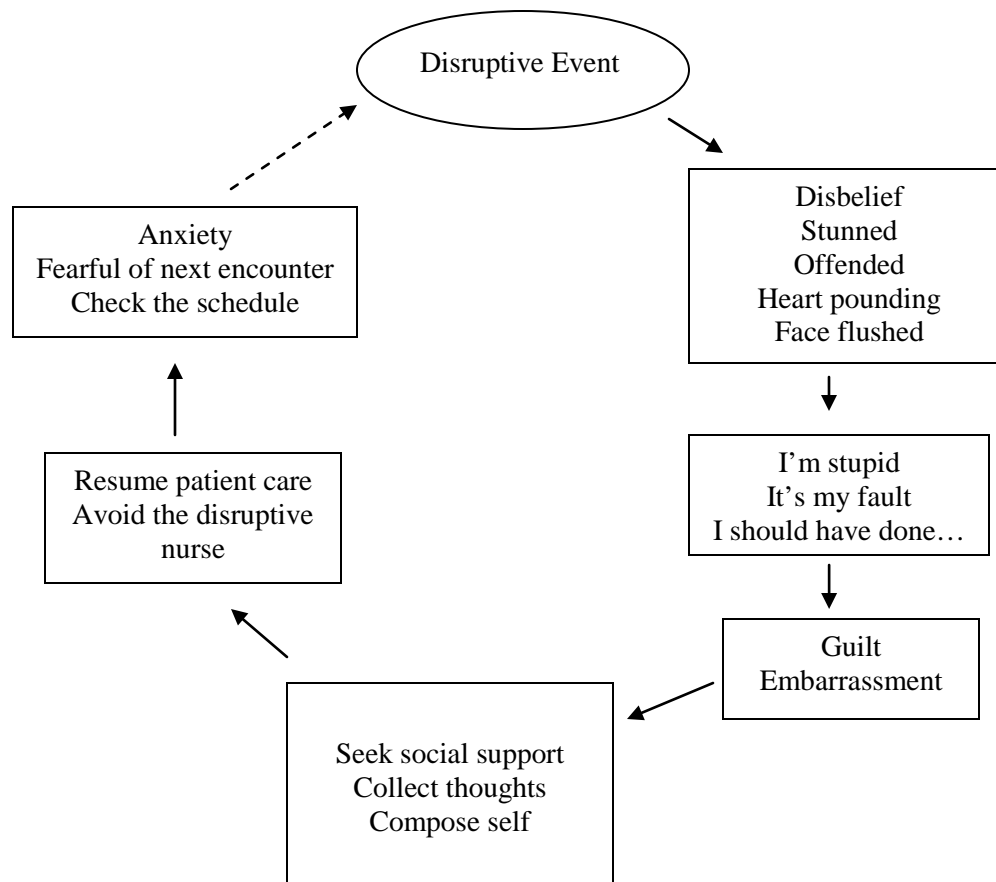


Figure 2. The consequences of DB during a shift.

Managing DB

Nurses might respond in the heat of the moment in a variety of ways. At the end of a shift, newer nurses especially, and a few experienced nurses, might desperately try to fix whatever error or issue led to the attack. Kelly, filling in the MAR times and continuing patient care after her shift, is an example. Others might ignore, walk away, dismiss, or excuse the outburst, or on rare occasion, confront the DB nurse. A few would report the nurse to the charge nurse or nurse manager.

Recovering from DB

After the shift, at home, the victim nurse, still struggling emotionally, may talk to spouses and family members, drink a glass of wine, and find themselves lying awake,

thinking about the event. When an event happened at the beginning of shift or mid-shift, the victim nurse upset by the event responded by taking time to talk to other nurses on the unit or composing themselves before feeling ready to resume patient care. Sandra talking about what occurred after a DB event said: “I talk to the nurses, like we work together, so I ask them about the behavior - is right or wrong - what should I do.” Geraldine, consoling a nurse after a DB event said: “I felt so sorry for her, she nearly cried, I tried to talk to her but she couldn’t listen at the time. It took a little while before she could carry on [with work].” The nurse might also avoid the disruptive nurse for the rest of the shift or several shifts. When distress persisted, the services of a psychotherapist were mentioned as an option by the nurses.

Preparing for DB

At home the victim nurse would think about returning to work and feel anxious or fearful as he or she anticipated another disruptive nurse encounter. Some nurses prepared by having quiet time, withdrawing from family, and gathering energy for the return to work. Nurses did not want to work with the disruptive nurses. At work, victim nurses checked to see if they would be interacting with a disruptive nurse at shift change. They began to feel anxious and their actions reflected this anxiety. They prepared anxiously, double- and triple-checking that all of their work was in order and reviewing the chart or patient histories in anticipation of the disruptive nurse’s questions. Nurses working the same type of shift as the disruptive nurses would check the schedule to see when they worked with a disruptive nurse again. When the disruptive nurse arrived at work, the cycle of DB may continue.

Summary

Two types of nurses initiated DB: disruptive nurses and stress-reactive nurses. The disruptive nurses exhibited a pattern of continual DB, distinctive behaviors which were

viewed as part of their personality, initiated DB at any time during the shift, and were indiscriminate with whom or where they initiated the behavior. The stress-reactive nurses initiated DB under stressful circumstances (e.g., a patient emergency). There was a range of behaviors from subtle to severe: the disruptive nurses' behaviors were severe and had significant effects on the nurses, while the stress-reactive nurses were predictable and their behaviors were less severe. Although victims of DB included all nurses and even other healthcare workers, nurses new to the unit and new graduate nurses were particularly at risk for and the leading victims of DB. The nature of DB was a mix of verbal, physical, and indirect behaviors that occurred in private and public. Public displays of DB were just as disturbing to the nurses, draining their energy and adding feelings of guilt and judgment. Lastly, after the initial emotional reaction, nurses reported a pattern of managing, recovering, and preparing for DB. Some of these behaviors were observable on the unit.

The Never-ending Story of Disruptive Behavior

At times, solving the problem of DB seemed almost impossible for the nurses and unit manager. A pattern of DB, especially by the most disruptive nurse, had been occurring for many years. The staff nurses reported, confronted, changed their perception of, and/or surrendered to the situation. Each of these strategies had unsatisfactory consequences and the nurses eventually became despondent. Meanwhile, the nurse manager struggled to follow the administrative processes laid out in the hospital's Code of Conduct policy leading to brief but temporary episodes of improvement. There was a seemingly never-ending rise and fall of DB.

Problems with Reporting

Nurses did not know that they could report DB, how to report DB, or to whom to address their complaints. Furthermore, nurses, fearing retaliation from the disruptive nurses, were reluctant to resolve or report the issue themselves.

Official Rules of Reporting

The hospital has a Code of Conduct policy that addresses inappropriate and disruptive behavior. The policy includes the purpose for the policy, a long list of examples of unacceptable verbal and non-verbal behavior, actions to take after experiencing DB, how and to whom to report DB (chain of command), and a description of the review and investigation of complaints. It is mandatory for all the healthcare workers in the hospital to receive education on the Code of Conduct policy annually.

During new employee orientation there is an hour-long informational session on the Code of Conduct. Nurses who recently completed orientation (nurses new to the hospital and new graduate nurses) said that with all the information they had in orientation it was hard to remember specifics about the Code of Conduct. Following hospital orientation nurses new to the hospital receive a six- to 12-week orientation on the unit of employment where they learn the unit routine. The length of orientation varies upon the nurse's level of experience and adaptability to the new environment. New graduate nurses continue on an extended one-year orientation program. During that time they are mentored by an experienced nurse on the unit and meet monthly with the hospital's new graduate coordinator or a unit-based educator to review various hospital policies and discuss socialization to the work place issues. At the fourth meeting, the organizational value of just culture is discussed, and during the sixth

meeting horizontal violence is discussed. The format is informal discussion and no written materials are distributed.

The new-graduate coordinator (person responsible for smooth transition of new graduate nurses into the workforce) said that the orientees don't often mention horizontal violence during those monthly meetings, but if they do it is discussed. The coordinator was surprised that I was conducting a study on the topic in the hospital since the new nurses did not talk about many events to her or the unit-based educators, and said that her assumption was that "we don't really have a problem with that in this hospital."

As mentioned previously, the rest of the nurses do mandatory annual education which includes reviewing the Code of Conduct and signing a document that they understand it. When asked, the unit nurses said that they were vaguely aware of a DB policy as one of the training items they have to review every year and mentioned that there was "some form that we have to sign every year."

Nurse Behavior is Reportable?

Nurses knew that patient-related incidents could be reported, but a few were unaware that behavioral issues of nurses could be reported. Charles, who had worked on the unit for more than four years, said that there was no mechanism or system in place to report nurse behaviors, and Darlene, who had been on the unit for 18 months, knew she could but did not know how.

Not Knowing How and to Whom to Report

The Code of Conduct states that DB events can be reported orally, in writing, or via a telephone hotline. Nurses reported events verbally or by e-mail, but most were not sure if

this was the correct mechanism. None of the nurses used the hotline. Charlotte said, “I wish there was a computerized mechanism with check boxes.”

Likewise, nurses did not always know to whom to report DB. The unit manager and charge nurse were the recipients of complaints most of the time. During the day, the nurses reported events to the manager orally if the unit manager was on the unit and available. During the night shift or on weekends, when the unit manager was not readily available, if a DB event was reported to the charge nurse, the charge nurse made a note on a shift report sheet and the report sheet was relayed to the unit manager when she arrived in the morning. On occasion, the department director and the Human Resources Department received reports of DB directly from the nurses. Two of the 16 nurses stated that they always report DB directly to the Human Resources department, while four nurses reported DB events to the Human Resources Department only when the issue was not resolved by their unit manager.

Reluctance of Resolving DB by Themselves

The Code of Conduct describes the steps to be taken in DB event: first try to resolve on your own, if unsuccessful, report to immediate supervisor (e.g., charge nurse or unit manager), then department director, vice president or compliance/abusive behavior hotline. For the most part, nurses avoided the first step of resolving it on their own. When there was a direct response it was in the form of confrontation. The nurses did not use the word “resolving.” New nurses especially were afraid of the disruptive nurses and let the situation dissipate by itself. Only a few reported it to the charge nurse or unit manager. Ella, a new graduate nurse, said “We are afraid—I usually won’t say anything.” Experienced nurses also tended to avoid the first step, some because they did not like confrontation and others, after repeated DB events, learned that the first step was futile because the disruptive nurses were

always able to justify their actions and behaviors. Alice said, “. . . she always had an answer for her actions.” In addition, there was a fear of retaliation. Renee, echoing the words of seven other nurses, said: “don’t expect there will not be repercussions.” The most disruptive nurse, working in a senior role, was assigned additional unit responsibilities including a task that affected every nurse’s work schedule. The nurses, wishing to protect their work schedule since it was a frequent vehicle for retaliation, were reluctant to confront and report the disruptive nurse. Renee said: “she [disruptive nurse] has an ace up her sleeve and she will play it.” Renee, in her story of reporting the disruptive nurse and retaliation, said that she had requested some vacation days and when she came back after a weekend off, “those days had been shifted—I was the only target—I was the only one whose days where changed, and it was very evident.”

Changing Perceptions about DB

DB events were traumatic for all the nurses and all spoke about it in a negative way. Phrases commonly used to describe DB included that it “caused anguish” and “makes us miserable.” In their pain and distress about DB, two nurses found something positive about their experiences. Both were new graduate nurses and they framed DB as an opportunity for learning and self-growth. Lanie and Ella stated that through the DB events they learned to be organized, structured, detailed, and prepared. Lanie said that she learned to develop a “thick skin” and not to be so sensitive when she received critique. Ella said: “It made me stronger.”

Surrendering to the Situation

After experiencing DB from the disruptive nurses and reporting their behavior multiple times, but not seeing an improvement in the situation, the nurses felt powerless and many stopped reporting the behavior. Many nurses echoed Beverly’s sentiment that “nothing

changes . . . finally I just gave up.” Rowena said, “why try—because obviously they do tolerate bullying, they do tolerate it—every year we have to sign a thing that it’s no tolerance—I sign it knowing that it’s a lie—they do tolerate it . . .” The nurses felt that they were powerless to effect change, that the reporting system was hopeless, and so they tried their best to work with the situation. Beverly said, “I ultimately understood that I could not change her—I just keep telling myself she is who she is.” Charles said, “what can we do—we need a job—so we work with her.”

The Seemingly Never-ending Rise and Fall of DB

When the nurse manager heard about a DB event, she followed the policy, encouraging nurses to talk to the disruptive nurse about the event in an effort to resolve it. As described earlier, nurses omitted this step, or after trying, gave in to the disruptive nurse. Renee, feeling angry and overwhelmed after multiple DB events over many years, believed that the situation with the most disruptive nurse had evolved beyond the individual nurse’s ability to take action. Upset that the manager and hospital administration was not taking responsibility, she said, “we took the steps for many years . . . we can’t talk to her [disruptive nurse] anymore—it’s like pushed off on us, they [the management] need to handle that now.”

Five nurses said that they confronted the disruptive nurse. How and when the confrontation occurred depended on the nurse and the situation. Some nurses confronted a disruptive nurse immediately, while others waited until misbehavior occurred a few times or until they reached a point when they felt they absolutely had to confront the disruptive nurse. Steve said: “. . . the first time . . . she started on me right there in the hallway . . . I said ‘stop, don’t talk to me like that.’” David and Rhonda experienced DB in the hallway and the nurse’s station, respectively. David said, “. . . that was the second time she did it to me and I

just cut the conversation off, right in the middle of it . . .,” while Rhonda waited longer: “I was really counting—like the third time now, the fourth time I need to do something . . .” When DB occurred in a patient room there were mixed reactions. Accused of giving an intravenous medication at an incorrect rate, Geraldine confronted the disruptive nurse immediately after leaving the room. Geraldine said, “don’t ever say that in front of the patient . . . no, you have to make things right . . .” She demanded that the disruptive nurse “apologize to me and the patient in front of the patient—she did,” while Charles, in a similar situation, said that he was so appalled by a DB event in the presence of a patient that he just left and went home.

Direct confrontation with the disruptive nurses was only partially effective. Steve said standing his ground did not stop the behaviors. Geraldine, after confronting the disruptive nurse several times, said that it was effective in eliminating direct behaviors, but the hostility was still present: “. . . she doesn’t pick on me . . . behind my back she will say something, but she won’t come out and say it in front of me.”

Even though many nurses did not try to resolve the issue or confront the disruptive nurse, the unit manager investigated DB when she received oral or written complaints. Many complaints were vague; for example “she was rude to me.” If the nurse was unwilling to be more specific (date, time, exactly what happened, witnesses) the unit manager had more difficulty investigating the complaint. The unit manager checked who was on shift and asked those nurses if there were any DB events that day. Alice said, “[the manager] has asked me for all this information I just said—I will give you this information, but I work with this person, so please keep it confidential because I fear retaliation with this person.” Thus, nurses were not very forthcoming and for the manager it felt like she was “pulling teeth

sometimes to get information.” The nurses understood that the manager could investigate the complaint better if they put it in writing and provided proof or witnesses, but those details would put the nurses in an untenable position. Steve said, “. . . they have to have a lot of facts or evidence before somebody can be terminated, I understand that, but in the process it [puts] me in an awkward position because I have to deal with this person over and over.”

The manager understood that the nurses were afraid to give details and in an attempt to ease their fears, she offered to write down the sequence of events for the reporting nurses, let them review it and if accurate, and let the nurse initial and date the document. The response to this offer was limited as the nurses explained to the manager that the disruptive nurse would know who made the report. Nurses who witnessed DB events also did not want to become involved. David, after being approached by the manager to provide a witness account of a DB event said, “so now I find myself responding to e-mails [from the manager] this week—so I’ve been broiled— [I’m] kind of in the middle . . . and I don’t want to be.”

When the unit manager had enough information to address a complaint, she met with the disruptive nurse in her office to hear his/her side of the story. As with the nurses, the disruptive nurses were skilled at explaining, justifying, and presenting their actions to the manager. The manager said: “. . . she made it very hard to pin her down.” As complaints about the disruptive nurses were gathered, the manager followed the policy step by step. The manager evaluated each complaint by following a just culture algorithm (see Appendix H). Some complaints of DB did not meet the criteria for further action and the manager put a note on the nurse’s personal folder. If the complaints that did meet criteria or the manager received another complaint about the nurse it set the process for further action in motion. There are several steps to follow when addressing DB. Each phase of the process has

requirements that need to be met and this takes time. The official process starts with an employee counseling session (this does not constitute corrective action). This session consists of the nurse and manager meeting to discuss what happened and an agreement or solution regarding future behavior. If the manager continues to receive reports about DB a corrective action report is required. At this stage the nurse is subject to take some action (e.g., counseling, or further education such as anger management). If reports of DB continue the nurse receives a pre-disciplinary conference notification letter, a conference is called, and the nurse may prepare a formal rebuttal. The nurse may receive a warning. Next, after the conference, if the nurse does not meet the requirement set at the conference and the situation does not improve, the nurse may be suspended without pay. The final step after each of these stages is completed is dismissal. The nurse manager said that a serious disciplinary action such as receiving a written warning (after disciplinary conference) usually curbs the disruptive nurses' behavior, but a written warning has a time limit that expires after 12 months. If no serious reports about DB are made in the time limit the documentation process has to start over. The nurse manager said that the disruptive nurses initiated DB during their warning period, but due to the reluctance of nurses to report the behavior she was not always able to pursue the next steps.

Nurses spoke about a pattern of behavior that occurred. When a major DB incident occurred involving the disruptive nurses, nurses and other healthcare workers reported the incident. Small groups of nurses would write a letter together or consult each other on the wording and tone of the letter. The manager would address the disruptive nurse's behavior; she would tone down her behavior or "be quiet" for one to two weeks and then resume her DB. Rowena exemplifies this behavior in her statement:

The behavior was quiet for one weekend and then back to normal—nurses wrote long letters about this nurse—it doesn't seem like anything happened—a slap on the wrist and then it will be quiet for a while and then you can see it build back up—so you see things aren't taken care of—there is never any explanation given.

Alice said, “it takes about three weeks and then starts at square one all over again. It starts—it's a pattern—it never fails.”

The nurses felt that when they made complaints they did not know what became of their complaint. Rowena said: “She [the manager] said that she would take care of it, but I don't know what happened.” Nurses wanted to know that the disruptive nurse issue was being addressed. They wanted an apology, mediation, or conflict resolution, but in many cases this did not happen. Uncertainty about what was being done was frustrating and a lack of resolution dissatisfying. Steve exemplified the sentiments of several nurses when he said “I wanted an apology—I never got an apology—it was just swept under the rug.” After some DB events the manager did try to resolve a conflict between nurses. Darla told me that a mediation session was called between her and a disruptive nurse. The disruptive nurse did not show up for the meeting. Darla said, “I felt like [the manager] could have done a better job resolving the situation, because she basically just let her go . . . and we didn't even get anything resolved.” The prolonged exposure to DB and lack of solving the problem left the nurses feeling frustrated and angry toward the manager. Renee, as if talking to the manager, said angrily: “What is wrong with you? Why can't you stand up for us? You have basically fired other people, but you won't take the steps to do something [about the disruptive nurse].” Nurses felt that the problem with the most disruptive nurse had gone on for too long. Renee said, “[The disruptive nurse is] getting her hand slapped—been in the office many times—she is untouchable.”

Nurses were frustrated with the system and blamed the manager or felt that she was unable to deal with the situation. They attributed this to inaction, avoidance, and skill deficit. Ella said, “. . . our manager cannot deal with and avoids conflict.” Steve also exemplifies what many nurses said when he stated, “the manager does not have the ability to discipline this particular nurse—it is a problem because the manager knows and is aware of this and she has not done anything.” Two nurses believed that the most disruptive nurse was exerting some power over the unit manager and that was the reason for the manager’s inaction, “. . . she [disruptive nurse] told me one night that she had all this information on our manager that she could use . . . that was a form of blackmail . . . she was devious.”

The unit manager said that she met frequently with the unit director and a resource person in the Human Resources Department for guidance and counseling on how to best manage the situation. On two separate occasions after major DB events the unit manager, trying to address the problem, called mandatory meetings with all the nurses. Both events involved the most disruptive nurse. The first event concerned the night nurses and meetings were held weekly in an attempt to “fix” the problem. Rowena said rhetorically:

. . . how am I going to fix it? . . . you [manager and administration] need to fix this problem - which to me is another example where they were not addressing the real issue—and we were just sitting there and they’re wanting us to fix it—how am I going to fix it?

Those meetings stopped without resolution. The second event involved all the nurses from both the day and night shift and one large meeting was called. The unit manager and director were present. The most disruptive nurse dominated that meeting with discussions about good work relationships. The other nurses felt the disruptive nurse did not realize that the meeting was about her behavior. Steve stated,

She just dominated the conversation—she started talking about herself—how good she is, how people should do a, b, c, d, but little did she know that she was the subject—actually she was saying this is not good, people should not behave like this.

None of the management or nurses at the meeting confronted or contradicted her. The meeting left the nurses feeling unsure about management's position, how aware they were of the problem, and their willingness to do something about it. DB on the unit remained unresolved. Steve stated, "... she got away with it ... she is still here."¹

Summary

Nurses were not familiar with the Code of Conduct and many were unaware that they could report DB. Nurses also did not know how or to whom to report, which resulted in them using a variety of different avenues to report behavior, and in some cases not following the chain of command. Nurses felt powerless to resolve a problem with the disruptive nurses since the disruptive nurses justified and argued for their actions. Eventually nurses gave up trying to talk to or report the disruptive nurses and surrendered to the situation.

Additionally, the nurses were reluctant to report the disruptive nurses and feared retaliation. This made the task of the nurse manager very difficult since nurses did not want to report in writing and witnesses did not want to step forward or get involved. The manager tried different strategies such as writing the report for the nurses and having meetings to discuss behavioral issues and teamwork on the unit, but these were not successful.

The process of investigating and abiding by the corrective action policy involved a long paper trail and sustained complaints about DB. The nurses reported a pattern of ebb and flow in the disruptive nurses' behavior, especially after major DB events which sparked an increase of complaints; however, after a short period of time the DB behavior resurfaced.

¹ During the last two weeks of data collection the most disruptive nurse was involved in a major disruptive event. At my first return visit, after concluding data collection, the nurses told me that the most disruptive nurse had been terminated.

Meanwhile, the nurses believed that no action was being taken. Frustration and anger grew as victim nurses wanted feedback, an apology, or a mediation meeting after making a complaint. Some nurses blamed the manager and administration for not taking action and allowing the behavior.

CHAPTER 5

DISCUSSION

The purpose of this qualitative study was to explore the phenomenon of DB among nurses in a hospital environment. I explored nurses' perspectives of DB, and examined the circumstances, contexts, and process of DB among nurses in a healthcare organization. This chapter discusses the major findings and conclusions drawn from the research data. Next, strengths and limitations for the study are discussed including recommendations for clinical practice and future research. Lastly, a summary and final remark concludes this body of work.

Major Findings

On the nursing unit two predominant types of nurses initiated DB: disruptive nurses and stress-reactive nurses. A small group of disruptive nurses had a profound effect on the rest because of the incessant nature and severity of DB they initiated. The behaviors were viewed as part of the disruptive nurses' personalities or being. The disruptive nurses initiated DB at any time during the shift, and were indiscriminate as to who the targets were. During data collection the victim nurses focused on the most severe and emotionally upsetting behaviors when conveying their experiences.

Stress-reactive nurses were the second type of nurses who initiated DB. These nurses initiated DB only under stressful conditions (e.g., patient emergency, multiple admissions at the same time). As with the disruptive nurses, the rest of the nurses quickly learned who the

stress-reactive nurses were, but in contrast to the disruptive nurses, the stress-reactive nurses' behaviors were more predictable. The behaviors by the stress-reactive nurses were less severe and did not cause a great deal of distress for the nurses.

The data collection methods (especially participant observation) of this study led to the discovery of information which could not be captured with questionnaires or interviews. This study identified types of nurses initiating DB, a finding that is in contrast with all others who categorize perpetrators in broader terms such as a job title or position (e.g., nurses, co-workers, managers, administrators; Budin et al., 2013; Celik et al., 2007; Khalil, 2009; Lemelin et al., 2009; Rowe & Sherlock, 2005; Spence Laschenger et al., 2009; Vassey et al., 2009). To date, little has been published studying perpetrators of bullying. At present, the view is that individual characteristics may play a role, but that the vast majority of bullying incidents are not significantly influenced by personality (Hutchinson et al., 2008). Setting aside the influence of individual characteristics has resulted on a continued organizational approach to explain DB among nurses. This study found that on this nursing unit nurses viewed individual characteristics of the disruptive nurses as crucial. All other previously discussed organizational antecedents (refer to Chapter 2) faded in light of the strong characters of the disruptive nurses, indicating that individual characteristics of nurses cannot be dismissed.

On the other hand, organizational antecedents such as increased workload, number of admissions, and time constraints applied to stress-reactive nurses since these were the times when they initiated DB. This finding again suggests that nurses who initiate DB are different in character and that all perpetrators cannot always be categorized under broad labels such as "nurses" or "co-workers."

Other organizational antecedents (e.g., lack of autonomy, participation in decision making) were not present in the findings, neither were the theoretical perspectives discussed in Chapter 2. This may be due to the micro-level nature of the study and the overpowering effect that the disruptive nurses had on the nurses which narrowed and focused DB to a unit and inter-personal level. Identifying which types of nurses initiate DB and the degree to which the behavior of each extends can help future researchers and nurse managers develop a multitude of interventions to minimize DB and the consequences of DB in different ways.

Similar to other studies, the demographic antecedent level of experience applied to this study, since new graduate nurses were a particular target of DB from the disruptive nurses (Camerino et al., 2008; Griffin, 2004; Longo, 2007; Randle, 2001, 2003; Vassey et al., 2009). The nurses' perception was that the disruptive nurses targeted any newcomer on the unit. In addition, and not discussed in the literature, this study found that physicians, pharmacists, and other healthcare workers were not immune to DB from the disruptive nurses.

As described in the literature, DB was very prevalent among nurses on the nursing unit (Chipps et al., 2013; Rosenstein & O'Daniel, 2008; Rowe & Sherlock, 2005; Vessey et al., 2009). The nurses anticipated DB nearly every shift, especially when disruptive nurses were on duty. The types and range of behaviors varied from subtle to severe and mirrored those already known (Hinchberger, 2009; Johnson & Rea, 2009; Quine, 2001; Simons, 2008; Vessey et al., 2009). The most prevalent and severe behaviors on this unit were verbal, followed by physical, and lastly work-related behaviors. Work-related behaviors were indirect, retaliatory in nature, and included changing the monthly work schedule without notice.

In this in-depth observational study I had an opportunity to explore the responses of nurses to DB. Past studies have categorized the consequences of DB by listing emotional, psychological, physical, and social effects (Camerino et al., 2008; Edward, Ousey, Warelow, & Lui 2014; Hutchinson et al., 2006a; Yildirim, 2009). This study had similar findings, for example that nurses experienced emotional and physical consequences, that they felt miserable and some even felt hated. However, this study adds new knowledge as it lays out a sequence of reactions after nurses experience DB. Due to the profound nature of DB by the disruptive nurses, nurses reacted by developing a pattern of managing, recovering, and preparing for DB—from when a DB event occurs to anticipating returning to work facing disruptive nurses again. Nurses exhibited these behaviors at home and at work. A significant finding is that nurses take time out at work to recover from DB by talking to colleagues or composing themselves before resuming patient care. This may have an impact on patient care and safety. While at work, these and preparatory behaviors (e.g. studying of patient information) were observable. Information about the aftermath of DB and how nurses prepare for a future encounter is lacking in the literature.

Finding a positive outcome in this study and in the literature on this topic is a rarity, but an interesting response from two nurses was the view of a productive result from the destructive nature of BD. Although these nurses were afraid of the disruptive nurses, they felt that the actions they took (e.g. making sure all work was completed and that they were fully prepared for any question) and psychological adaptations they made to face an emotional challenge (develop a thicker skin, be stronger) to avoid DB made them better nurses.

In addition, another finding from this study includes that in response to frequent DB; the unit nurses protected or shielded new nurses from the disruptive nurses as long as they

could. Shielding behaviors included the mentor nurses warning new nurses about the disruptive nurses, giving report to the disruptive nurses (instead of new nurse) for as long as they could and teaching new nurses strategies of how to give report in an efficient way and how not to get drawn into conflict.

Participant observation also captured new information about the nature and effect of public DB. This finding concludes that a constant stream of negative comments and complaining in public by nurses is a form of DB, is very disturbing to nurses, and has consequences. There is no reference of this behavior in the literature on DB or if patients hear these comments or complaints, which opens the door for further exploration.

Lastly, the path of data collection and analysis led to the important discovery and detection of multiple difficulties with reporting and solving DB which produced a seemingly never-ending cycle of DB. Similar to Ferns and Chojnacka (2005) and Vassey et al. (2009), this study found that nurses underreport DB and reported that reasons for this included that there was a lack of awareness of the reporting system and that reporting incidences did not lead to change. Early on during data collection it became evident that reporting DB was a problematic issue and the importance of taking the exploration of this area a step further was evident. This study found that nurses did not know that they could report DB, did not know how to report it, or to whom to report DBs. While some nurses did report disruptive nurses (especially after major DB events), they became angry and frustrated when the behaviors continued. This study initiated an exploration of the process of reporting, investigating, and follow up that occurs that includes the nurse managers' point of view. The manager could not always act on nurses' complaints because the nurses feared retaliation from the disruptive nurses. It made following a long drawn out formal correctional procedure even longer as it

could not come to full effect. In turn, the nurses felt that the manager and hospital administration were not dealing with DB effectively. It is thus far the only study that expands on the problems encountered with reporting and clearly explains all the difficulties involved and the different trails that reporting, non-reporting, and confronting takes.

Limitations of the Study

One limitation of the study was that the sample was one nursing unit at one healthcare facility in one geographic location (southeastern United States). Only nurses from the selected nursing unit were interviewed. In addition, a limitation may be that some of the participants did not fully disclose their thoughts during the interview process; however, I believe that most of the nurses did fully disclose their thoughts and feelings due to the rapport and trust I built with them, the neutral setting for the interviews (Kvale & Brinkmann, 2009), multiple eyewitness accounts of the same DB event; copies of DB reports, rebuttals, and other texts provided to me; and the sheer emotion present in their voices as they shared their stories. Unfortunately, two of the disruptive nurses declined my invitation for an interview (no reason provided), thus I am unable to present a fully balanced representation of DB. The most disruptive nurse avoided or ignored me by not acknowledging my presence, making any eye contact, or showing any interest in me or the study. The second most disruptive nurse was interested in the study and agreed to an interview at first, but when approached for a date and time, she stated that she had changed her mind and declined. These two disruptive nurses may have perceived my presence as a threat to their employment and themselves as victims. The third most disruptive nurse did agree to an interview, but only described incidences where she was the victim of the

behavior. Despite this, the setting, participants, and data collection methods provided rich data on the phenomenon of DB.

An important limitation was my inexperience with data collection and analysis. Although I had prior experience of interviewing, I prepared as well as I could for participant observation and data analysis. I adjusted quickly to participant observation, and after an initial struggle with the sheer amount of data, I focused the analysis of the data and identified new and exciting findings. Throughout the data analysis I challenged myself to find alternative ways of looking at the data and discussed my feelings, thoughts, and insights extensively with my dissertation chair.

Implications at Nursing Practice and Organizational Levels

Respect, compassion, and dignity for patients, families, and colleagues are the cornerstone of the American Nurses Association's Code of Ethics. Findings of this study suggest that in terms of colleagues, the cornerstone principle of the Code to which every nurse is bound is being breached. The findings of this study provide a starting point for a number of directions for the future.

First, since this study identified a high incidence of DB, there is a need to raise awareness of the nature of DB. Schools of nursing, healthcare facilities, and local, state, and national nursing organizations can play an important role in preparing students, new graduates, and working nurses by providing them with much needed information about DB. At the unit level, an opportunity for open discussion about DB on the unit needs to be provided in a safe environment. The ability to recognize and discuss DB is the first step toward solving it.

Second, since this study highlighted difficulty in communication between the victim and the disruptive nurse in resolving DB, nurse managers and nurses, especially new graduate nurses, must receive education in communication skills (e.g., managing professional relationships, teamwork, conflict resolution, assertiveness training, mediation, crucial conversation) either during their education at a school of nursing or as part of continuing education hours. Adding communication skills into all nurses' basic competencies for employment would help employers, patients, families, and all healthcare workers.

Third, in light of nurses' lack of knowledge regarding the Code of Conduct policy, all healthcare facilities must change or improve upon the education of nurses on the Code of Conduct and other Workplace Violence policies (explaining all procedural steps). For easy access to information, the Code of Conduct policy needs to be visibly displayed in common areas of the nursing unit. In addition, I recommend simplifying and standardizing reporting procedures.

Fourth, since this study identified that the nurses experienced difficulty with unit manager efforts to deal with DB, unit managers need to respond to each complaint immediately and earnestly so that nurses do not feel the need to skip members in the chain of command. Unit managers also need to facilitate discussion or mediation between the victim nurse and disruptive nurse if the two are not able to do so by themselves. It is also important for the unit manager to validate victims and witness nurses' emotions, beliefs, and points of view. Additionally, since nurses in this study clearly identified the need for feedback after reporting an event, nurse managers should provide feedback (within legal limits) to the victim nurses regarding steps taken to resolve the issue.

Lastly, due to the traumatic nature of DB on all involved, counseling and support for the unit manager, victim nurses, and all the nurses witnessing and enduring DB need to be offered by the healthcare facility.

While these recommendations may not fully solve the problem of DB, they are a step in the right direction.

Implications for Future Research

To my knowledge, this is the first study where participant observation on a nursing unit was implemented to directly observe DB. In doing so, this study produced new knowledge about DB which provides opportunity for future research. Studies should be conducted to confirm the findings of two categories of nurses who engage in DB. Nurse leaders in the field of DB have called for many years for interventions to reduce DB; thus, the confirmation of and distinction between disruptive and stress-reactive nurses is important in light of planning interventions to reduce DB. Different types of interventions will be applicable to each category of nurse.

This study drew attention to two new areas: (a) the reactions of nurses in terms of managing, recovering, and preparing for DB; and (b) the effects of public DB (e.g., shouting down the hallway, constantly complaining out loud). Only the surfaces of these areas were explored and future studies should further investigate these important aspects of DB.

This study emphasized the need for communication skills to deal with conflict and difficult situations or people. A future study investing school of nursing curricula to determine the extent to which communication skills applicable to dealing with DB is included in nursing education will be valuable.

Lastly, this study stressed the importance of the reporting process and its associated difficulties. To prevent DB from continuing, causing endless suffering and nurses becoming despondent with the process, a study focusing on the reporting process of DB and subsequent follow-through desperately needs to be initiated. Such a study can provide more detailed insights into the reporting process than was achieved with this study and can lead to significant changes to reduce DB.

Conclusion

Key groundbreaking contributions of this study add to our knowledge of DB related to types of perpetrators, reactionary patterns, the phenomenon of public DB, and numerous complex difficulties with reporting. This new knowledge and further exploration of DB based on these findings is essential for planning future interventions focusing on changing behaviors by disruptive and stress-reactive nurses.

DB is a global epidemic that seriously affects the lives of many nurses. We need to maintain healthy workplaces with healthy nurses, otherwise we defeat our caring purpose and instead of remembering the joy of nursing we remember the nurses who hurt us. Steve said: “She [disruptive nurse] has been the worst; I am going to remember her for the next 20 years, even into retirement.”

Appendix A

Commonly Used Terms Denoting DB and Typical Definitions of Each

Term	Typical Definition(s)
Disruptive Behavior	<p>“Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions” (Joint Commission, 2008, ¶2).</p>
Bullying	<p>“Bullying involves repeated forms of negative or hostile behaviors occurring over time which may involve offending, harassing, or negatively affecting the work tasks of the individual targeted” (Hutchinson, Wilkes, et al., 2010, p. 174).</p> <p>“A situation where one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where in the target of bullying has difficulty in defending himself or herself against these actions” (Johnson, & Rea, 2009, p.85).</p>
Horizontal violence	<p>Horizontal violence: “hostility and aggressive behavior perpetrated by one member of a group towards another” (Lemelin, Bonin, & Duquette, 2009, p. 156)</p> <p>“Horizontal violence is a consistent (hidden) pattern of behavior designed to control, diminish, or devalue another peer (or group), that creates risk to health and/or safety” (Hinchberger, 2009, p. 38).</p> <p>“Horizontal violence most commonly takes the form of psychological harassment, which creates hostility, as opposed to physical aggression. This harassment involves verbal abuse, threats, intimidation, humiliation, excessive criticism, innuendo, and exclusion, denial of access to opportunity, disinterest, discouragement and the withholding of information” (McKenna, Smith, Poole, & Coverdale, 2003, p.2).</p>
Workplace Incivility	<p>Workplace incivility is a “low intensity, deviant behavior with ambiguous intent to harm the target in violation of workplace norms and mutual respect. Uncivil behaviors are characteristically rude and discourteous, displaying a lack of regard for others” (Hutton, & Gates, 2008, p. 168).</p>
Verbal Abuse	<p>“Verbal abuse is communicated through words, tone, or manner that disparages, intimidates, patronizes, threatens, accuses, or disrespects toward another” (Celik, Celik, Agirbas, & Ugurluoglu, 2007, p. 359).</p> <p>“Verbal abuse is any communication perceived by another nurse as ruthless criticism, either personal or professional” (Rowe, & Sherlock, 2005, p. 243).</p>
Workplace Violence	<p>Workplace Violence is a multifaceted problem, which may take on several forms such as verbal abuse, physical assaults, aggression, harassment, bullying, intimidation, threatening, as well as obscene behaviors (Camerino, Estryn-Behar, Conway, van der Heijden, & Hasselhorn, 2007, p. 36).</p> <p>Workplace violence includes emotional verbal, physical and sexual abuse. Recipients of both emotional and verbal abuse can feel humiliated and degraded (Anderson, 2002, p. 352)</p>

Appendix B

Typology of Disruptive Behaviors (Leiper, 2010)

Verbal Abuse (VA)

Verbal Abuse – Overt:

- criticizing (being criticized, put-down, etc.)
- name calling (being called a derogatory name, etc.)
- raising voice (being shouted or yelled at, etc.)
- blaming (being blamed for things you are not responsible for, repeated reminders of mistakes, etc.)
- threatening (being verbally threatened, hints that you should quit, etc.)
- mocking (being addressed in unprofessional terms, being subject to practical jokes, etc.)

Verbal Abuse – Covert:

- sabotage (e.g., undermining your efforts, exaggerated complaints about you to your supervisor)
- isolation (e.g., ignoring or excluding you)

Verbal Abuse – Sexual:

- sexual harassment/intimidation (sexist remarks directed to you, sexual fantasy being described about you, etc.)

Physical Abuse

Physical Abuse – to person:

- non-sexual abuse (pushing, hitting, twisting arms, intimidation using body, etc.)

Physical Abuse – to property:

- damage to property (slashing your car tires, etc.)

Physical Abuse – Sexual:

- sexual assault
- sexual intimidation (being given a suggestive look, body parts exposed to you, etc.)

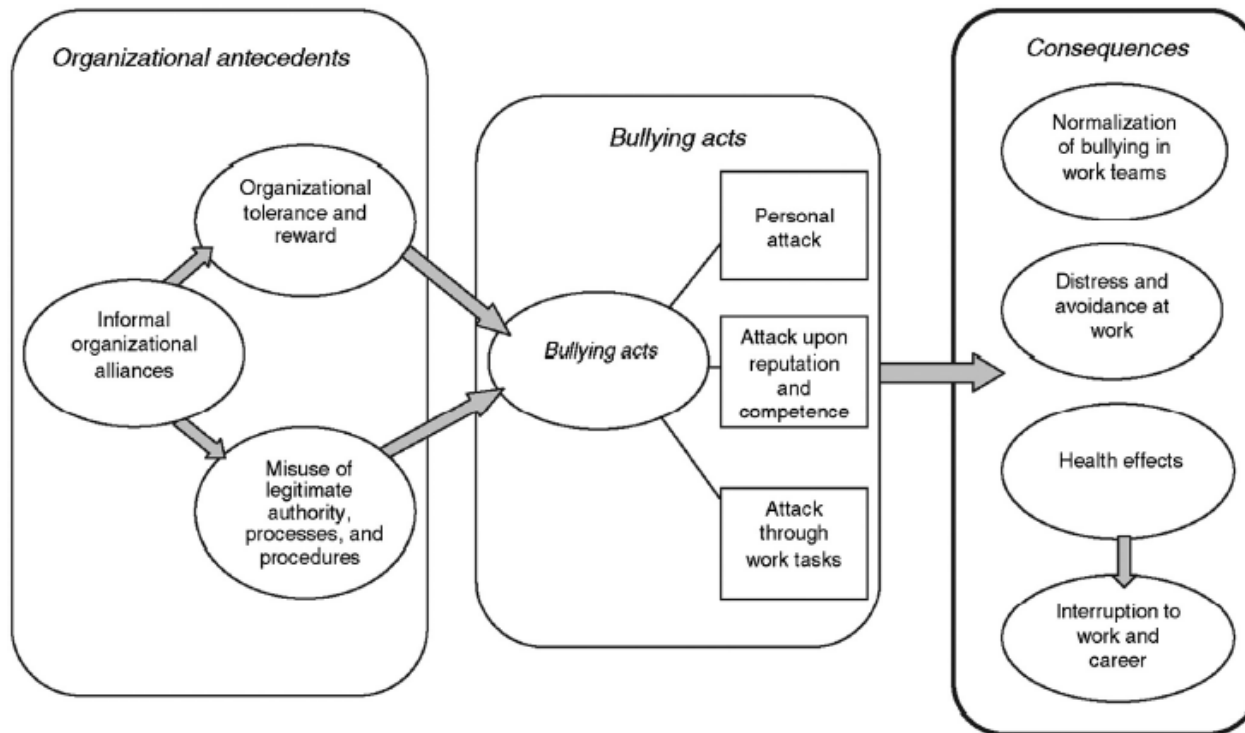
Work-related Abuse

- Workload (unreasonable workload, pressure to produce results, etc.)
- Sabotage (shifting goalpost without telling, removing responsibility without telling, etc.)
- Use of power (pressure not to use benefits, use of disciplinary measures to intimidate, restriction of resources, etc.)

Appendix C

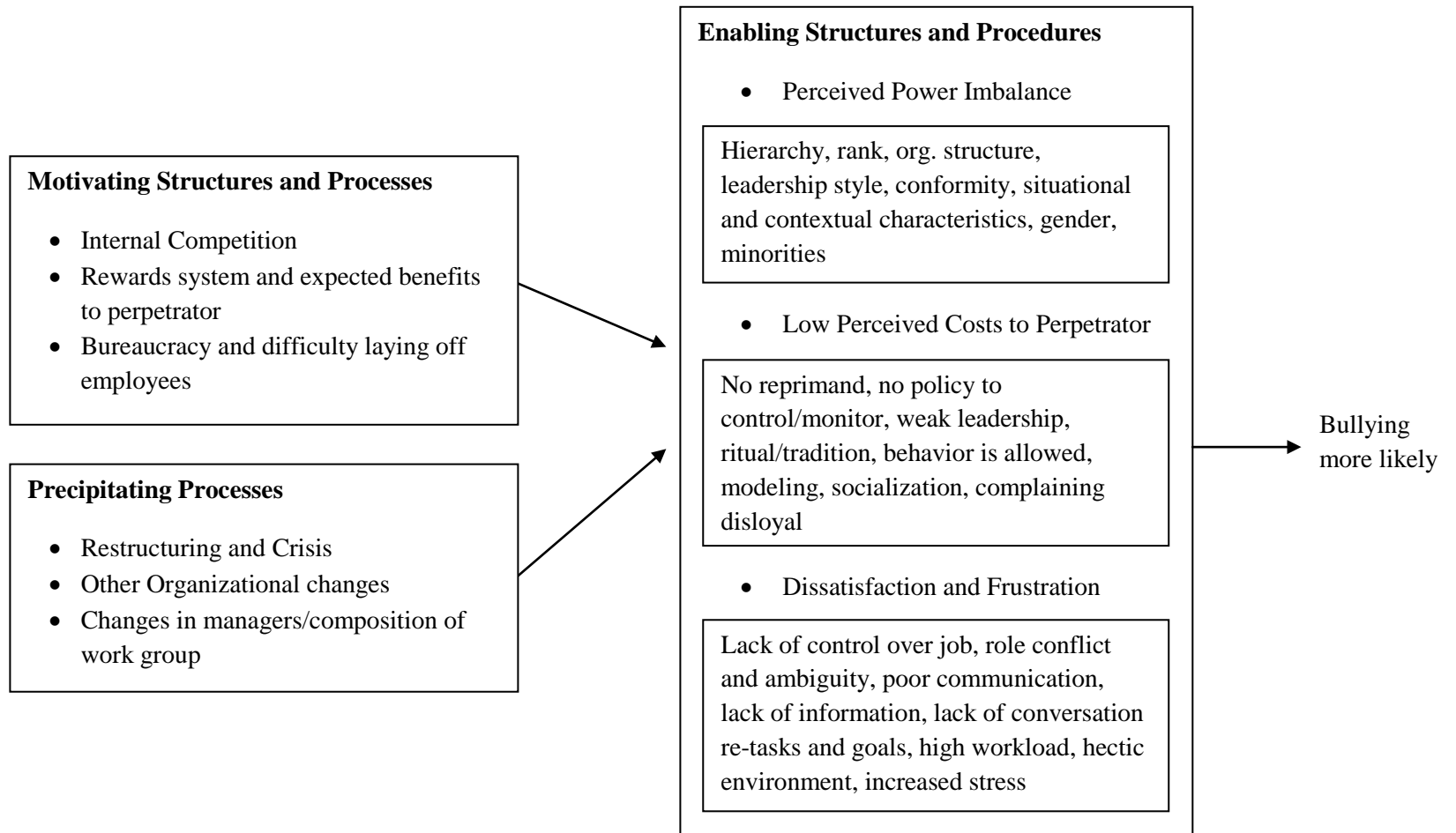
Model for Bullying in the Workplace

Model for workplace bullying in the workplace: organizational characteristics as critical antecedents
(Hutchinson, Vickers, Jackson, & Wilkes, 2008).



Appendix D

Model of Enabling, Motivating, and Precipitating Structures and Processes in the Work Environment That Contribute to Bullying (Adapted from Salin, 2003)



Appendix E

Settings Where Nurses Experienced DB

Nurse	Nurses Station	Hallway	Patient Room	Locker/ Break Room
Steve	x	x		
Katrina	x			
Sandra	x	x		
Rowena	x	x		
David		x		
Kelly	x			
Renee	x	x		
Ella		x		
Charles	x	x	x	
Lany	x		x	x
Geraldine	x	x	x	
Beverly	x			
Samantha	x	x		
Alice	x	x	x	
Darlene	x	x		x
Rhonda	x	x		

Appendix F

Steve's DB Experience

Example of diagrams the researcher made for each DB event: Steve's DB experience

STEVE

When: Change of Shift

Where: Nurses' Station/Hallway

What lead up to it:

Unexpected
confusion about a
medication order

Steve's Characteristics:

New Nurse
"Still shaky"
"Going by the book"

Thinking:

Why are you
questioning me?
This is not right!

Feeling:

Frustrated
Pushed (verbal)

DB Behavior:

Excessive questioning
Accusing
Calling him a liar
Loud voice
Shouting
Intimidating
Following down the
hallway

Consequences:

Actions:

Walk away

Feelings:

Felt Insulted
Hurt Ego
Felt Surprised

Reporting:

Told Manager

Resolution:

No Apology
"swept under the
rug"

Future Action:

Confrontation
Changed Behavior

Appendix G

Code of Conduct

Administrative Manual	
Policy Name	Code of Conduct
Policy Number	COC-DB101
Date this version effective	June 2009
Responsible for Content	Office of Internal Audit and Compliance

I Description

Provide a code of conduct to all employees, staff, and faculty.

II Rationale

The health care organization is committed to supporting a culture that values integrity, honesty and fair dealing among all health care team members, and promoting a caring environment for patients, visitors, physician, nurses, and other health care workers. Teamwork and good communication promote a culture of patient safety. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care and satisfaction as well as employee satisfaction and safety. All health care team members at every level of the organization will support the Code of Conduct through their interactions with patients, visitors, clinicians and staff.

Toward these goals we strive to maintain a workplace that is free from harassment and intimidation. This includes behavior that could be perceived by a reasonable person as inappropriate or harassing, or that does not endeavor to meet the highest standards of professionalism. While this type of conduct is not pervasive in our facilities, no hospital or clinic is immune. Awareness and cooperation at all levels is necessary to implement this policy effective and maintain a safe working environment.

III Purpose of the Code of Conduct

The purpose of the Code of Conduct is to:

- clarify the expectations of all health care team members during interactions with any individual
- encourage the prompt identification and resolution of alleged inappropriate conduct, and
- encourage identification of concerns about the wellbeing of a health care team member whose conduct is in question, including referral to the Employee Assistance Program or Physician's Health program, as appropriate.

IV Policy

A. We care about and are committed to:

1. Our Patients and Their Families – delivering quality health care and outstanding service is fundamental to everything we do.
2. Our Team – attracting and retaining the best team members is of paramount importance to our Health Care System. We will do this by becoming the health care employer of choice and by providing an environment that:
 - Pursues the highest level of safety and quality
 - Focuses on treating patients and colleagues with courtesy, honesty, respect, and dignity.
 - Recognizes people for their achievements and capabilities
 - Encourages the open exchange of views, and
 - Does not tolerate offensive and disruptive behavior.
3. Our Community – Dedicating ourselves to finding ways to improve health of all in our State is central to our leading, teaching, and caring.

B. Inappropriate or Disruptive Behavior

Offensive conduct may be written, oral, or behavioral. Examples of inappropriate conduct would include but are not limited to:

1. Inappropriate words

- Using profane, disrespectful, insulting, demeaning or abusive language
- Shaming others for negative outcomes
- Making demeaning comments or intimidating remarks
- Having inappropriate arguments with patients, family members, staff or other care providers
- Having overly familiar conversations that violate professional boundaries with patients, family members, staff or other care providers
- Making negative comments about other health care team members (orally or in chart notes)
- Passing severe judgment or censuring colleagues or other health care team members in front of patients, family members, staff or other care providers
- Having outbursts of anger
- Acting in a manner that others would describe as bullying
- Making insensitive comments about a patient or other health care team members' health care condition, appearance, situation, and the like
- Making threats, and
- Making jokes or non-clinical comments about race, physical appearance or socio-economic or educational status.

2. Inappropriate Actions

- Throwing or breaking things
- Refusing to comply with known and generally accepted practice standards such that the refusal inhibits staff and other care providers from delivering quality care
- Using or threatening unwarranted force with patients, family members, staff or other care providers
- Repeated failure to respond to calls or requests for information or persistent lateness in responding to calls for assistance when on-call or expected to be available
- Failing to work collaboratively or cooperatively with others
- Making rude or lewd gestures
- Striking or touching inappropriately a patient family member, staff or other care provider
- Ignoring potentially harmful situations or failing to report them appropriately
- Creating rigid or inflexible barriers to requests for assistance/cooperation.

C. Duty to Report Disruptive or Inappropriate Behavior

Health care team members should if possible and appropriate, first try to resolve situations involving disruptive or inappropriate behavior informally among themselves. If such resolution is unsuccessful, the disruptive or inappropriate behavior should be reported. Additionally, egregious disruptive or inappropriate behavior should always be reported.

1. To promote patient safety and the safety of family members, visitors and other health care team members are responsible for reporting disruptive or inappropriate behaviors. Threats, assaults, or other criminal behavior that require immediate attention by law enforcement must first be reported to the hospitals' Police at 123-1231, or to 911 for an emergency.
2. Every individual (the reporter) should feel free to file a complaint in good faith about abusive or unprofessional behavior without fear of reprisal or retaliation.
3. Anonymous complaints will be considered to the extent possible, but the response to anonymous complaints may be limited when there is insufficient information to support the investigation.
4. Complaints may be made through the chain of command, e.g. immediate supervisor, Department Director, or Vice President, in writing, orally, or through the Compliance/Abusive Behavior Hotline, 345-3453. When a complaint is received by someone out of the chain of command it shall be referred to the Health Care System Office of Internal Audit and Compliance for review. The Compliance Office will work with or refer the concern to the appropriate support functions in the hospital to make certain the incident is investigated or reviewed consistent with the policy for the affected entity.

5. Health care members who intentionally falsely accuse other health care team members of disruptive or inappropriate behavior will be appropriately disciplined.
6. Individuals may report inappropriate behavior where they were involved in questionable behavior. In such cases the individual may receive some consideration for their cooperation in the investigation, but they remain responsible for their behavior.
7. Any complaints that are reported that are not tied to the Health Care System by location or operational responsibility will be referred to the appropriate entity and will not be recorded as a Health Care System incident.

D. Investigation and Review of Complaints

1. Each incident of disruptive behavior is investigated and documented by staff trained to discern the severity of the violation, the presence of mitigating factors, and the existence of risk of harm to patients. When appropriate notification of incidents will be made to the Human Resources and legal Affairs functions of the hospital for their input and guidance in the investigation and evaluation process.
2. A multidisciplinary oversight committee will monitor the progress of code implementation as well as Code violations, and determine system factors that may be contributing to excessive conflict in the work environment.
3. Upon receipt of a complaints, the following screening measures will be taken within 14 days:
 - A member of the Office of Internal Audit and Compliance will meet with the reporter to review the complaint and all available details, including names of others who may have knowledge of the incident
 - A member of the Office of Internal Audit and Compliance will meet with all who have knowledge of the incident
 - A member of the Office of Internal Audit and Compliance will review medical records or other documentation where relevant.

The Office of Internal Audit and Compliance may work with or turn over the review to others as appropriate including, but not limited to, Human Resources or the Hospital Police.

4. If the information obtained in the investigation fails to demonstrate the incident complained of took place, or if the reported behavior did not, in fact, deviate from expectations of professionalism, the Director of the Office of Internal Audit will find that there is no basis for the concern. In this event, the complaint will be retained in the Office of Internal Audit and Compliance file in accordance with this policy, with a clear indication that it was unfounded together with the information that substantiates this.
5. If it is determined that inappropriate or disruptive behavior in violation of this Code has taken place, the matter will be referred to the employment supervisor and proceed according to the chain of command if appropriate. Investigatory procedures that are utilized for other Compliance Helpline reports may be utilized for investigations of inappropriate and disruptive behavior. The employment supervisor and/or others will cause investigations and actions to occur, as appropriate, and will report the results to the Office of Internal Audit of any final action taken as a result of the referral.
6. If the behavior complained of poses an immediate threat to patient care or the safety of others, or if the outcome of a prior complaint has indicated as much, the matter will be referred to the Legal Department or Hospital Police for appropriate action.

E. Confidentiality

The complaint investigation procedure is intended to be confidential to the maximum extent possible. All parties to the process are expected to respect and maintain the confidentiality of the process and not divulge details of the investigation unless required or permitted by law.

F. Documentation

The record of the investigation and its deposition will be retained in the Office of Internal Audit and Compliance.

G. Education

1. All health care team members will receive annual education with documented competency on the Code of Conduct.
2. The Office of Audit and Compliance will report on observed trends in terms of Code violations to the Health Care Executive Council. A summary of the information will be reported to the Audit and Compliance Committee and the Joint Committee of the Board.
3. Progress of Code implementation will be monitored through the use of a validated, reliable employee/clinician survey tool on at least an annual basis. Results will be shared with all Committee and Board members.

H. Sanctions

Disruptive conduct and inappropriate workplace behavior may be grounds for suspension, termination of a contract, cancellation, suspension, restriction or non-renewal of privileges, or corrective action up to and including termination of employment.

I. Prohibition against Retaliation

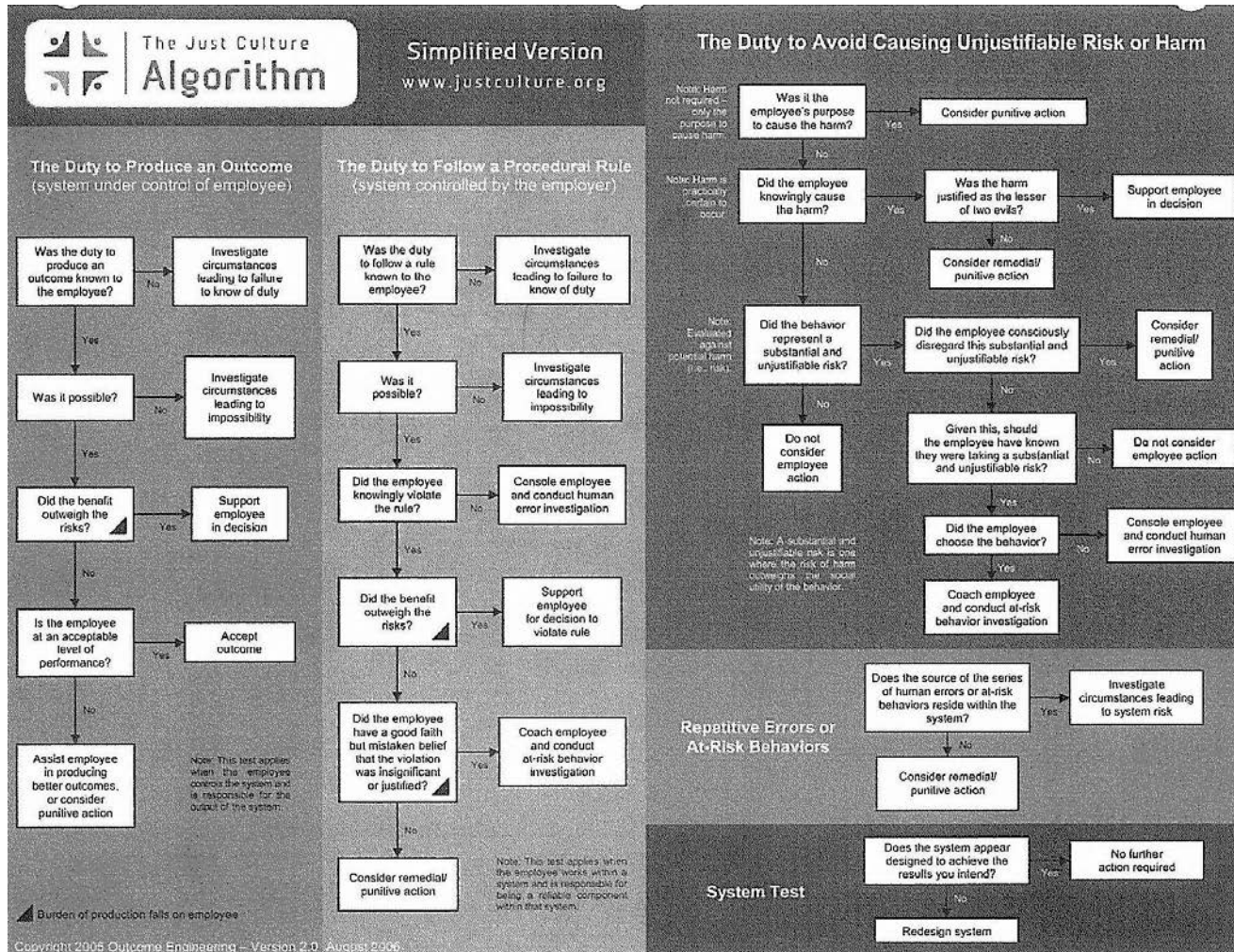
Retaliation against anyone who reports disruptive or inappropriate behavior, or who participates in an investigation as a witness or in any other capacity, is prohibited and will not be tolerated.

J. Related Policies

Domestic Violence
Workplace Violence
Criminal Investigations
Unlawful Harassment
Grievance Resolution
Corrective Actions
Employees Assistance Program

Appendix H

Just Culture Algorithm



Event Investigation The Five Rules	The Response to An Event	Definitions	
<p>Rule 1 Causal Statements should clearly show the "cause and effect" relationship.</p> <p>Rule 2 Negative descriptions (e.g. poorly, inadequate) should not be used in causal statements.</p> <p>Rule 3 Each human error should have a preceding cause.</p> <p>Rule 4 Each procedural deviation should have a preceding cause.</p> <p>Rule 5 Failure to act is only causal when there was a pre-existing duty to act.</p>	<p>Single Human Error</p> <ul style="list-style-type: none"> • Console employee • Conduct Human Error Investigation <p>At-Risk Behavior</p> <ul style="list-style-type: none"> • Coach employee • Conduct At-Risk Behavior Investigation <p>Reckless Behavior</p> <ul style="list-style-type: none"> • Counsel employee • Use remedial action to change behavior, where appropriate • Use disciplinary action to change behavior <p>Repetitive Errors or At-Risk Behaviors</p> <ul style="list-style-type: none"> • Investigate to determine source of repetitive errors or at-risk behaviors • If source resides in system, change the system • If source is within employee, consider remedial and then punitive action to address risk 	<p>Knowingly – practically certain that conduct will cause harm</p> <p>Impossibility – condition outside of employee's control that prevents duty from being fulfilled</p> <p>Counseling – a first step disciplinary action: putting the employee on notice that performance is unacceptable</p> <p>Human error – inadvertently doing other than what should have been done; a slip, lapse, mistake</p> <p>At-risk behavior – behavior that increases risk where risk is not recognized, or is mistakenly believed to be justified</p> <p>Substantial and unjustifiable risk – a behavior where the risk of harm outweighs the social utility associated with the behavior</p>	<p>Purpose – conscious objective to cause harm</p> <p>Social utility – the societal benefits derived from a behavior; the value the judging body puts on the behavior</p> <p>Coaching – supportive discussion with the employee on the need to engage in safe behavioral choices</p> <p>Reckless behavior – behavioral choice to consciously disregard a substantial and unjustifiable risk</p> <p>Punitive action – punitive deterrent to cause an individual or group to refrain from undesired behavior</p> <p>Remedial action – actions taken to aid employee including education, training, assignment to task appropriate to knowledge and skill</p>
<pre> graph LR A[Causes of Human Error] --> B[Human Error] B --> D[Outcome] C[Causes of At-Risk Behavior] --> E[At-Risk Behavior] E --> D </pre>	<p>System Investigation</p> <p>How was the risk being managed ahead of the event?</p> <ul style="list-style-type: none"> • Employee to manage personal risk? • Organizational control of performance shaping factors? • Organizational control of skill/competency? • Organizational maintenance of high perceptions of risk? • Barriers put in place to prevent error? • Recovery to catch error before becoming a critical outcome • Redundancy to allow success through multiple paths? 	<p>At-Risk Behavior Investigation</p> <ul style="list-style-type: none"> • What type of at-risk behavior? <ul style="list-style-type: none"> • Error in risk v. utility decision? • Failure to make risk v. utility decision? • Why was the decision made? <ul style="list-style-type: none"> • Incentives to cut the corner? • Perceptions of risk? • How prevalent is the behavior? <ul style="list-style-type: none"> • Individual or group? • Rate? 	<p>Human Error Investigation</p> <p>Explain human errors by identifying the performance shaping factors:</p> <ul style="list-style-type: none"> • Information • Equipment/tools • Job / task • Qualifications / skills • Individual factors • Environment/facilities • Organizational environment • Supervision • Communication

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